Connecticut Department of Social Services

State of Connecticut Balancing Incentive Payment Project

October 31, 2012

STATE OF CONNECTICUT BALANCING INCENTIVE PAYMENT PROJECT

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STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

October 31, 2012

Jennifer Burnett
Centers for Medicare and Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Burnett:

Connecticut's Balancing Incentive Payment Project (BIP) application is attached requesting $68,531,264 in enhanced Federal Medical Assistance. The Department of Social Services is Connecticut's Medicaid agency. The Department has been working steadily toward rebalancing the long term supports and services (LTSS) in our state for over a decade. We believe in consumer choice and dignity of risk.

Connecticut has shown a commitment to the goals of the BIP from 1998 when the Long-Term Care (LTC) Planning Committee was authorized by the legislature, to the Olmstead Task force created in 2000, to the Real Choice Systems Change grant as well as the C-PASS grant, the Quality Improvement Grant and the Aging and Disability Resource Center Grants, though the Money Follows the Person Rebalancing Demonstration, which was awarded in January of 2007 and is working at a much higher capacity today. Connecticut is moving in the right direction, but still has work to do to achieve the goal of an excess of 50% of LTSS expenditures on home and community based services by September 30, 2015. We appreciate the additional support this grant will be able to provide.

The Department is in favor of the "No Wrong Door/Single Entry Point System" (NWD/SEPS), conflict-free case management services, and a core standardized assessment instrument. We believe that once these are in place, the LTSS application and assessment processes will be streamlined, eligibility processes will be more consistent, and access to services for aged and disabled individuals will be increased statewide.

The Department of Social Services will partner and collaborate with several other state agencies as well as Independent Living Centers, Areas Agencies on Aging, and other stakeholders including the state legislature. Dawn Lambert will serve as the contact person. Her direct phone contact is 860-424-4897.

Thank you for considering our application. We look forward to starting this project.

Sincerely,

Kate McEvoy
Interim Director of Health Services Division

Project Abstract

The State of Connecticut's Department of Social Services, Division of Health Services (DHS), with the Legislative and stakeholder support, seeks approval for application to the Centers for Medicare and Medicaid Services for participation in the Balancing Incentive Payment Program (BIP). The $72,780,505 enhanced federal medical assistance received will be used to expand community long-term services and supports (LTSS) and develop infrastructure necessary to support uniform access and a more streamlined process for persons seeking community LTSS. Ultimately, the goal of Connecticut's BIP project is to remove policy, procedure and access barriers that prevent persons from receiving equitable community LTSS and that lead to unnecessary institutionalization.

Strategies that the State of Connecticut will explore to ensure the success of this project include, but are not limited to:

1. Development and implementation of a SEP/NWD/ADRC with physical access within each of Connecticut's 169 towns;
2. Coordination and implementation of a toll free call in number;
3. Development and implementation of a SEP/NWD/ADRC web based portal in coordination with the Health Insurance Exchange and the DHS ConneCT;
4. Coordination and implementation of a comprehensive resource base that includes services at a local level in coordination with other ACA initiatives;
5. Design and implementation of an expedited process for granting long-term care Medicaid;
6. Design and development of a web based level 1 comprehensive assessment;
7. Design and development of a standard, web based level 2 comprehensive assessment with data integrated within the DHS data warehouse;
8. Development and implementation of a web based "My Accounts" within ConneCT that will support persons applying for and receiving services from DSS by providing electronic access to both financial and functional documents and status updates;
9. Design and implementation of conflict free case management

These strategies are already integrated into Connecticut's overarching Strategic Rebalancing Plan. Connecticut is committed to full implementation of the plan and to removing any barriers that prevent Medicaid participants from having a choice to receive services in the community. Supply and demand projections for LTSS at a town level have just been completed. With an understanding of what needs to be done to build the necessary supply of services, Connecticut stands ready to lead change with the necessary passion and energy.

Preliminary Work Plan

Over time this Balancing Incentive Program work plan will become more detailed and firm target dates will be developed.

Category	Major Objective/Interim Tasks	Due Date (from Work Plan submission)*	Lead Person	Status of Task	Deliverables
General NWD/SEP Structure	**All individuals receive standardized information and experience the same eligibility determination and enrollment processes**				
	• Develop standardized informational materials that No Wrong Door/Single Entry Points (NWD/SEPs) provide to individuals	6/30/13	Dawn Lambert	In Progress	Informational materials
	• Train all participating staff on eligibility determination and enrollment processes	6/30/14	Dawn Lambert	Not Started	Training agenda and schedule
	A single eligibility coordinator, "case management system,' or otherwise coordinated process guides the individual through the entire functional financial eligibility determination process. Functional and financial assessment data or results are accessible to NWD/SEP staff so that eligibility determination and access to services can occur in a timely fashion. (*The timing below corresponds to a system with an automated Level 1 screen, automated Level 2 assessment and an automated case management system. NWD/SEP systems based on paper process should require less time*.)				
	• Design system (initial overview)	6/30/13	Dawn Lambert	In Progress	Description of the system
	• Design system (final detailed design)	12/31/13	Karen Law	Not Started	Detailed technical specifications of system
	• Select vendor (if automated)	3/31/14	Dawn Lambert	Not Started	Vendor name and qualifications
	• Implement and test system	12/31/14	Karen Law	Not Started	Description of pilot roll-out
	• System goes live	6/30/15	Dawn Lambert	Not Started	Memo indicating system is fully operational
	• System updates	Semiannual after 6/30/15	Karen Law	Not Started	Description of successes and challenges
NWD/SEP	**State has a network of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency**				
	• Identify the Operating Agency	10/31/12	Dawn Lambert	In Progress	Name of Operating Agency
	• Identify the NWD/SEPs	3/31/13	Karen Law	In Progress	List of NWD/SEP entities and locations
	• Develop and implement Memorandum of Understanding (MOU) across agencies	9/30/13	Karen Law	Not Started	Signed MOU
	NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance.				
	• Identify service shed coverage of all NWD/SEPs	6/30/13	Dawn Lambert	In Progress	Percentage of State population covered by NWD/SEPS
	• Ensure NWD/SEPS are accessible to older adults and individuals with disabilities	12/31/13	Dawn Lambert	In Progress	Description of NWD/SEP features that promote accessibility

Category	Major Objective/Interim Tasks	Due Date (from Work Plan submission)*	Lead Person	Status of Task	Deliverables
Website	**The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP system.**				
	• Identify or develop URL	6/30/13	Karen Law	In Progress	URL
	• Develop and incorporate content	9/30/13	Karen Law	Not Started	Working URL with content completed; screen shots of main pages
	• Incorporate the Level I screen *(recommended, not required)*	9/30/14	Karen Law	Not Started	Screen shots of Level I screen and instructions for completion
1-800 Number	**Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPS for assessments.**				
	• Contract 1-800 number service	12/31/13	Dawn Lambert	Not Started	Phone number
	• Train staff on answering phones, providing information and conducting the Level I screen.	12/31/13	Dawn Lambert	Not Started	Training materials
Adver-tising	**State advertises the NWD/SEP system to help establish it as the "go to system" for community LTSS**				
	• Develop advertising plan	9/30/13	Dawn Lambert	In Progress	Advertising Plan
	• Implement advertising plan	12/31/13	Dawn Lambert	Not Started	Materials associated with advertising plan
CSA/CDS	**A Core Standardized Assessment (CSA), which supports the purposes of determining eligibility, identifying support needs and informing service planning, is used across the State and across a given population. The assessment is completed in person, with the assistance of a qualified professional. The CSA must capture the CDS (required domains and topics).**				
	• Develop questions for the Level I screen	9/30/13	Karen Law	Not Started	Level I screening questions
	• Fill out CDS crosswalk (see Appendix H) to determine if your State's current assessments include required domains and topics	3/31/13	Karen Law	Not Started	Completed crosswalk(s)
	• Incorporate additional domains and topics if necessary *(stakeholder involvement is highly recommended)*	9/30/13	Dawn Lambert	Not Started	Final Level II assessment (s); notes from meetings involving stakeholder input
	• Train staff members at NWD/SEPs to coordinate the CSA	3/31/14	Dawn Lambert	Not Started	Training materials
	• Identify qualified personnel to conduct the CSA	3/31/14	Dawn Lambert	Not Started	List of entities contracted to conduct the various components of the CSA
	• Continual updates	Semiannually after 3/31/14	Karen Law	Not Started	Description of success and challenges

Category	**Major Objective/Interim Tasks**	Due Date (from Work Plan submission)*	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	**States must establish conflict of interest standards for the Level I screen, the Level II assessment and plan of care processes. An individual's plan of care must be created independently from the availability of funding to provide services.**				
	• Describe current case management system, including conflict-free policies and areas of potential conflict.	3/31/13	Dawn Lambert	In progress	Description of pros and cons of case management system.
	• Establish protocol for removing conflict of interest	12/31/13	Dawn Lambert	Not Started	Protocol; if conflict cannot be removed entirely explain why and describe mitigation strategies
Data Collection and Reporting	**States must report service, outcome, and quality measure data to CMS in an accurate and timely manner.**				
	• Identify data collection protocol for *service data*	6/30/13	Dawn Lambert	Not Started	Measures, data collection instruments, and data collection protocol
	• Identify data collection protocol for *quality data*	6/30/13	Dawn Lambert	Not Started	Measures, data collection instruments, and data collection protocol
	• Identify data collection protocol for *outcome measures*	6/30/13	Dawn Lambert	Not Started	Measures, data collection instruments, and data collection protocol
	• Report updates to data collection protocol and instances of *service data* collection	Semiannually after 6/30/13	Karen Law	Not Started	Document describing when data was collected during previous 6-month period and updates to protocol
	• Report updates to data collection protocol and instances of *quality data* collection	Semiannually after 6/30/13	Karen Law	Not Started	Document describing when data was collected during previous 6-month period and updates to protocol
	• Report updates to data collection protocol and instances of *outcome measures* collection	Semiannually after 6/30/13	Karen Law	Not Started	Document describing when data was collected during previous 6-month period and updates to protocol
Sustainability	**States should identify funding sources that will allow them to build and maintain the required structural changes**				
	• Identify funding sources to implement the structural changes	6/30/13	Dawn Lambert	In Progress	Description of funding sources
	• Develop sustainability plan	6/30/14	Dawn Lambert	Not Started	Estimated annual budget to maintain the structural changes and funding sources

Category	Major Objective/Interim Tasks	Due Date (from Work Plan Submission)*	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	**States must make an effort to coordinate their NWD/SEP system with the Health Information Exchange IT system.**				
	• Describe plans to coordinate the NWD/SEP system with the Health Information Exchange IT system	6/30/13	Dawn Lambert	In progress	Description of plan of coordination
	• Provide updates on coordination, including the technological infrastructure	Semiannually starting 6/30/13	Karen Law	Not Started	Description of coordination efforts

*Please replace the number of months with an actual date.
**If States do not submit satisfactory information regarding data collection protocol, they will be required to submit this information on a quarterly basis.

Signature of Lead of Operating Agency

Name: Kate McEvoy
Agency: Department of Social Services
Position: Interim Director of Health Services Division

Signature of Lead of Oversight Agency (Medicaid)

Name: Kate McEvoy
Agency: Department of Social Services
Position: Interim Director of Health Services Division

John Salomone
Town Manager

TOWN OF NEWINGTON

120 Cedar Street Newington, Connecticut 06111

Senior and Disabled Center

Dianne Stone
Director

October 29, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of the Newington Senior and Disabled Center, a multi-purpose agency serving older adults and people with disabilities in the community, I fully support the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). We share your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide.

As a municipal agency, we appreciate this effort to ensure that our residents will be served more efficiently and effectively and we look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Dianne Stone
Director

Phone: (860) 665-8778 Fax: (860) 667-5835
srcenter@newingtonct.gov
www.newingtonct.gov

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

October 29, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Ms. McEvoy,

I am pleased to offer this letter of support for the Connecticut Department of Social Services - Health Services Division's Balancing Incentive Payments Program (BIPP) application to the Centers for Medicare and Medicaid Services.

The Connecticut State Unit on Aging (SUA) has overseen the state's existing No Wrong Door / Single Entry Point for Long Term Supports and Services for older adults, persons with disabilities, and caregivers since the program's inception in 2008. Also known as the state's Aging & Disability Resource Centers (ADRCs) or "Community Choices" to the public, we maintain a statewide toll-free phone number for in-state callers, utilize a statewide Long Term Supports & Services / ADRC website, and will be available statewide before the end of the calendar year.

The SUA and Community Choices looks forward to continued partnership in effort to further streamline the application and assessment processes and standardize eligibility determinations as evidenced by the sharing of our ADRC Intake, Screening, and Assessment tools for the intent of developing a uniform assessment tool. Our mutual interests in the growth of ADRCs, which includes establishing a Medicaid reimbursement mechanism, through the Administration for Community Living's 2012 ADRC Enhanced Options Counseling funding opportunity further demonstrates our efforts to rebalance, streamline, and improve access to services for older adults and persons with disabilities in Connecticut.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Margaret Gerundo-Murkette
Acting Director, State Unit on Aging

University of Connecticut Health Center
Center on Aging

Administrative Office

October 29, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of the University of Connecticut Health Center, Center on Aging, I am pleased to offer my support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP). We share the BIPP goal of reducing institutional bias in Medicaid and increasing access to non-institutional Long Term Services and Supports (LTSS), and we applaud your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increase options for receiving these services in the community. Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for older adults and disabled individuals statewide.

I am especially pleased that the Center on Aging at the University of Connecticut Health Center has been a partner in the state's rebalancing efforts for many years. As you know, the Center on Aging identified the need for significant rebalancing in its 2007 State Long Term Care Needs Assessment. Julie Robison, PhD, and Noreen Shugrue, JD, MBA, MA, have extensive experience in evaluating and working collaboratively with many related programs including the Money Follows the Person Demonstration, Aging and Disability Resource Centers, Care Transitions and Options Counseling programs, and the Demonstration to Integrate Care for Dual Eligibles.

Their work is enhanced by the considerable resources of the UConn Center on Aging, which is home to many nationally recognized programs committed to improving the lives of older citizens through clinical care, education, and research. Among these, our accomplished clinicians and investigators have been leaders in the development and evaluation of innovative approaches to the coordination and person-centered management of such individuals,

Best wishes for success in the review process. We look forward to collaborating with the Department of Social Services to help achieve the goals of this project.

Sincerely Yours,

George A. Kuchel, MD, FRCPC
Professor of Medicine
Citicorp Chair in Geriatrics & Gerontology
Director, UConn Center on Aging
Chief, Division of Geriatric Medicine
University of Connecticut Health Center
email: kuchel@uchc.edu
website: www.uconn-aging.uchc.edu/

Wallingford Senior Center
WALLINGFORD COMMITTEE ON AGING INC.

October 26, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

The Wallingford Committee on Aging, Inc./Wallingford Senior Center is pleased to express both our support for and our willingness to participate in the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

William T. Viola

William T. Viola, Executive Director
Wallingford Senior Center
238 Washington Street
Wallingford, CT 06492
Tel. (203) 265-7753
Fax (203) 294-2117
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STATE OF CONNECTICUT
DEPARTMENT OF REHABILITATION SERVICES

October 31, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

The Department of Rehabilitation Services is pleased to have the opportunity to partner with the Connecticut Department of Social Services in their application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP). The main goal of the BIPP, to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS), is aligned with our own mission of providing access to independent living and employment services within the LTSS system. Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community, particularly options around employment and independent living.

We have created a single point of entry for employment, and we are eager to identify ways to incorporate this component into the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS). We are hoping this will streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for individuals with disabilities and the aging population.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Amy Porter, Commissioner
Department of Rehabilitation Services

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AARP Connecticut
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October 26, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of our nearly 600,000 members in Connecticut, AARP is pleased to support the Department's application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP). AARP is a nonprofit, nonpartisan organization with a membership that helps people 50+ have independence, choice, and control in ways that are beneficial and affordable to them and society as a whole.

Rebalancing the state's long-term care system to strengthen and expand home and community-based services and support family caregivers is a top priority for AARP Connecticut. The overwhelmingly majority of Americans age 50+ (89%) want to stay in their homes for as long as they can.[1]

Connecticut's BIPP proposal, which builds on Connecticut's Money Follows the Person demonstration and our state-funded services, provides an opportunity to rebalance the long-term care system and provide consumers the choice to live independently in the community. Implementation of a "no wrong door" system and a streamlined eligibility assessment process—as BIPP requires—will help connect consumers to community-based options and improve consumer satisfaction for all populations.

Additionally, BIPP's financial incentive offers a powerful motivation to promote high-quality care in the most appropriate and least restrictive setting. The enhanced funds will strengthen Connecticut's long-term care infrastructure and delivery system to better administer needed services. As a result, Connecticut will deliver quality care and better outcomes for those served. Moreover, the balance between home and community-based versus institutional care will be driven by consumer preference, not institutional bias.

AARP shares your commitment to rebalance Connecticut's long-term care system in a way that respects consumer choice and expands options for non-institutional care. We will remain an active consumer stakeholder by providing input into the Department's work and ongoing implementation efforts.

Sincerely,

Nora Duncan
State Director
AARP Connecticut

[1] Providing More Long-term Support and Services at Home: Why It's Critical for Health Reform. AARP Public Policy Institute, June 2009.

Caring From Every Perspective

CONNECTICUT COMMUNITY CARE, INC.

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Bristol, CT 06010-7472
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DIVISIONS:
Care Management Associates
Case Management Institute
CyberCAM

October 30, 2012

Ms. Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Kate,

Connecticut Community Care, Inc (CCCI) wholeheartedly supports the Connecticut Department of Social Services (DSS) application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP.)

I deeply appreciated the opportunity to participate in the October 11, 2012 "stakeholder" meeting and feel confidant that the Department recognizes the exceedingly complex nature of this undertaking and the critical role many organizations play in this historic rebalancing initiative. The language of "No Wrong Door" best represents the CCCI vision of multiple access routes to critical programs and services. We look forward to participating in more discussion regarding the expectations for conflict free case management. Given our thirty year history in clinical assessment for DSS programs we anticipate an opportunity to participate in a meaningful way in the development of a core standardized assessment instrument.

CCCI embraces all aspects of person-centered planning and self- determination. The vast majority of frail elders and persons with disabilities prefer community care to institutional care. All too often, programmatic design flaws, incompatible systems, and lack of knowledge of community resources preclude this. We are committed to working with the Department to introduce any and all meaningful, constructive change in this arena.

I look forward to our continued partnership to offer Connecticut citizens increased options for accessible, high quality community care services.

Sincerely yours,

Molly

Molly Rees Gavin
President

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

October 25, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of the Connecticut Department of Mental Health and Addiction Services' (DMHAS), I am pleased to provide this letter in support of the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Patricia A. Rehmer

Patricia A. Rehmer, MSN
Commissioner

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STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

October 24, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

I am pleased to provide my support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP). Connecticut shares the BIPP goal of reducing institutional bias in Medicaid and improving access to non-institutional long-term services and supports (LTSS) and is committed to creating a well balanced system of LTSS that reflect the values of individual choice, dignity and person-centered care.

By allowing Connecticut to increase its federal financial participation while working on rebalancing our system of LTSS, the BIPP will enhance our abilities to achieve our goals to provide more community choices for the individuals we serve in the state's Medicaid program.

The development and strengthening of a no wrong door/single entry point system, conflict-free case management services and a core standardization instrument is expected to help streamline the Medicaid application processes, standardize eligibility determinations statewide, and increase access to LTSS.

The Office of Policy and Management looks forward to working with the Department of Social Services to help achieve the goals of this project.

Sincerely,

Benjamin Barnes
Secretary

State of Connecticut
Department of Developmental Services

DDS

Dannel P. Malloy
Governor

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

October 26, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Re: Letter of Support

Dear Director McEvoy:

I am pleased to express our support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS).

The Department of Developmental Services (DDS) shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

The Department of Social Services (DSS) has submitted to CMS on behalf of the Department of Developmental Services (DDS) a Planning Advance Planning Document (APD), to build an integrated application suite to support operation of DDS's Home and Community-Based Services (HCBS) Waiver.

The integrated application suite will also ensure that any enhancements at DDS interface with DSS with a shared vision towards the components outlined by BIPP such as; the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS) to streamline the eligibility applications and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for all individuals accessing services from DDS and other state agencies.

We look forward to continuing our partnerships with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Joseph W. Drexler, Esq.
Deputy Commissioner

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460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov

Independence Northwest
1183 New Haven Road, Suite 200
Naugatuck, CT 06770

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of Independence Northwest: Center for Independent Living of Northwest CT, Inc., I am pleased to support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Independence Northwest shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

We also support the concept of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), which should streamline the application and assessment processes, and standardize eligibility determinations across the state. As an Aging & Disability Resource Center for the past three years, we have implemented a NWD/SEPS for northwestern Connecticut and agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide. We hope that the BIPP can expand upon groundwork established by Connecticut's ADRCs.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project and improve access to community based Long Term Support and Services for people with disabilities and elders.

Sincerely,

Eileen M. Healy
Executive Director

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel Malloy
Governor

October 25, 2012

Ms. Kate McEvoy, Esquire
Interim Director, Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

On behalf of the Department of Public Health I am pleased to express our support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide.

Strides have been made in Connecticut and the Department of Public Health supports maximizing consumer independence and choice.

We look forward to continuing our collaboration with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

JM/ jm

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410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

LONG TERM CARE OMBUDSMAN PROGRAM
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033
Telephone Number: (860) 424-5200 Fax Number: (860) 424-4966

November 1, 2012

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

I am pleased to express our support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP, the development of a "No Wrong Door/Single Entry Point System" (NWD/SEPS), should streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Nancy B. Shaffer
State Ombudsman

Agency on Aging
of South Central Connecticut

One Long Wharf Drive • Suite 1L
New Haven, Connecticut 06511
203-785-8533
www.aoapartnerships.org

Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

Dear Director McEvoy:

The Agency On Aging of South Central CT offers its support for the Connecticut Department of Social Services' application for the Centers for Medicare and Medicaid Services' Balancing Incentive Payments Program (BIPP), the main goal of which is to reduce institutional bias in Medicaid and increase access to non-institutional Long Term Services and Supports (LTSS). Our agency shares your commitment to rebalancing Connecticut's LTSS to reflect consumer choice and increased options to receive these services in the community.

Another component of the BIPP is support for a "no wrong door/single entry point system" (NWD/SEPS) that will streamline the application and assessment processes and standardize eligibility determinations across the state. We agree that implementation of the NWD/SEPS should improve access to services for aged and disabled individuals statewide and endorse the development of this component in partnership with Community Choices, the statewide Aging and Disability Resource Center.

We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

Ted Surh,
Interim Executive Director

cc: Dawn Lambert,
Margaret Gerundo-Murkette
Julie Gelgauda
Beverly Kidder

DISABILITY RESOURCE CENTER
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Kate McEvoy
Interim Director of Health Services Division
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

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We look forward to collaborating with the Department of Social Services to help achieve the goals related to this project.

Sincerely,

A LaCava

Anthony LaCava
Executive Director

Application Narrative

a. Understanding of Balancing Incentive Program Objectives: The State has demonstrated an understanding of and a commitment to the goals of the Balancing Incentive Program, and the concepts of a true NWD/SEP system for LTSS

The State of Connecticut has been actively advancing the objectives of the Balancing Incentive Program since 1998 when the Long-Term Care (LTC) Planning Committee was authorized by the legislature. The LTC Planning Committee was established for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. Policy development and the plan were required to assure that persons who need long-term services and supports had the choice to receive services and supports in the least restrictive environment appropriate. The LTC Planning Committee provides a forum for key legislators and Executive Branch agencies including the Department of Social Services (lead Medicaid agency), the Department of Public Health, the Department of Economic and Community Development, the Department of Transportation, the Department of Developmental Services, the Department of Mental Health and Addiction Services, the Office of Policy and Development, and others to collaborate and to coordinate LTC initiatives across the State. The LTC Planning Committee was created with an advocacy advisory committee chaired by the Commission on Aging. At the recommendation of the advisory committee, the LTC Planning Committee established the vision for the State's ongoing long term service and support (LTSS) initiatives as well as the rebalancing benchmark of 75% of all Medicaid LTSS participants receiving services in the community by 2025, an ambitious goal given that only 46% of LTSS participants were receiving services in the community in 2003. The vision recommended by the Advisory Committee and established by the LTC Planning Committee states: "Connecticut residents have access to a full range of high-quality LTSS that maximize autonomy, choice and dignity." This vision has guided all LTSS development and continues to guide the State's Balancing Incentive Program.

In 1999, just one year after the creation of the State's LTC Planning Committee, the Supreme Court ruled on the Olmstead v. L.C. case. As a result, Connecticut's Olmstead Task force was created in 2000 to develop the State's Olmstead Plan. Multiple meetings were convened during 2000 gathering a diverse group of stakeholders across disability, age and the Executive Branch. During the same time period, the Council on Developmental Disabilities funded the creation of the Olmstead Coalition. The Olmstead Coalition hosted a series of forums which brought national experts to the State and supported a dialogue between the national experts, the Coalition and Executive Branch officials.

The Olmstead Plan was still under development when the Federal Government announced the Real Choice Systems Change Grants requests for proposals in 2001. With many stakeholders already involved, the State was in a high degree of readiness for submitting proposals that reflected stakeholder input. In October 2001, the first Real

Choice Systems Change grant was awarded: the Nursing Home Transition Grant. Over the next few years, several other grants were awarded including the Real Choice Systems Change Grant, the C-PASS grant, the Quality Improvement Grant as well as Aging and Disability Resource Center Grants.

Key members of the Olmstead Task Force and the Olmstead Coalition formed the steering committee for the Nursing Facility Transition Grant in 2001. Meanwhile, the Olmstead Task Force completed the Olmstead Plan, "Choices are for Everyone", which was formally submitted and approved in 2002. The Nursing Facility Transition Grant, unable to meet its goal of 50 persons transitioned from institutions per year due to challenges in securing affordable, accessible housing, raised awareness within the State of the importance of developing a housing plus supports model and in 2002 Connecticut became the first State to establish a preference within the State's Housing Authority Section 8 program for persons transitioning from nursing homes.

While the Olmstead Plan had a focus on persons with disabilities, it was clear to the State that it had a great deal in common with the LTC Plan which to date, had more of a focus on elders. After adoption of the Olmstead Plan, it was determined that the State should have one plan moving forward and that the LTC Planning Committee should be expanded and focus on LTSS based on need rather than age or diagnosis. In 2004, the State submitted to the legislature the first combined LTC Plan. An additional key decision was made during 2004; the legislature approved the continuation of the Nursing Facility Transition Grant as a state program and continued to fund the former grant with State general revenue. The steering committee which was a grant requirement and dated back to the Olmstead Coalition and the Olmstead Task force in 2000, continued to meet and provide guidance to the Nursing Facility Transition state program.

In partnership with the Steering Committee, the State applied for and received funding for the Money Follows the Person Rebalancing Demonstration in January of 2007, the same year that the LTC Planning Committee received the University of Connecticut, Center on Aging Needs Assessment for LTSS. With a focus on rebalancing Medicaid LTC including but not limited to transitioning Medicaid LTSS participants from qualified institutions, the operational protocol development took over 18 months. The MFP Steering Committee continued to play a key advisory role during the development of the MFP Protocol as they do to date, meeting monthly for over 12 years. The demonstration began in December 2008 and included the state's commitment to a viable housing plus supports model by funding housing subsidies for anyone who otherwise qualified and who was transitioning under the demonstration. At that time, Connecticut anticipated the transition of 700 people from institutions to the community over a 5 year period. By December 2009, one year after the announcement, Connecticut had increased its projected number of transitions from 700 to 890; within another 6 months, Connecticut was demonstrating positive outcomes on all benchmarks.

On June 28, 2010, Connecticut submitted its first request for 100% administrative MFP funds requesting support for existing central office staff at the Department of Social Services and the establishment of 8 new positions. The most notable change funded by

this request was the co-location of financial eligibility determination for Medicaid with eligibility for community services, supporting Connecticut's vision of streamlined access for long-term care.

While the decade beginning in 2000 and ending in 2010 demonstrated both commitment to and advancement of the objectives of the Balancing Incentive Program (BIP), the past 30 months have demonstrated unprecedented change within the State. During the period from 2000 – 2010, the state worked to address service gaps within the waiver system. A Mental Health Waiver was created and implemented and the DDS Comprehensive and Independent Family and Support waivers became the first waivers in the United States to have individual budgets as the underlying financial framework. In addition, the State initiated the first Aging and Disability Resource Center (ADRC).

More specifically over the past 30 months, service gaps have been addressed and policy amended to increase choice for where persons requiring LTSS receive their services. More specifically:

1. The mental health waiver was amended to add 3 new services and create a less restrictive eligibility criteria;
2. Personal Care Assistance, assistive technology and adult family living were approved as new services under the elder waiver;
3. Adult family living and Independent Support Broker were approved as new services under the Personal Care Assistance Waiver;
4. The Medical Practice Act was amended to support nurse delegation of medication;
5. $30 million was appropriated to develop additional Supportive Housing increasing the number of units to over 4000;
6. $12 million dollars was appropriated to support the development of new congregate housing for elders;
7. Funding was appropriated by the legislature to create and implement a Core Standardized Assessment (CSA);
8. An informed choice nursing home closure protocol was developed and implemented in the closure of 8 nursing homes;
9. The first statewide conference on informed risk was held;
10. An application for implementation funding under the State Demonstrations to Integrate Care for Dually Eligible Individuals including long-term supports and services was developed and submitted to Centers for Medicare Innovation;
11. Administrative Services Organization was implemented to administer the State's Medicaid health coverage including intensive care management to support individuals in accessing primary preventative care, effective management of chronic conditions, and to assist with transitions between settings;
12. Additional Federal funding for Aging and Disability Resource Centers was awarded resulting in Statewide ADRC coverage;
13. Two Community Transition grants were awarded funding transitions in care at a local level and giving the State the opportunity to explore best practices;
14. Authorized by the legislature, a Strategic Rebalancing Plan was developed, funded and implemented in State Fiscal Year (SFY 13) to guide strategies, tactics

and metrics. A data map was developed as part of the strategic plan detailing existing and projected supply and demand for institutional and community LTSS at a town level;

Strategic Initiatives are demonstrating progress as reflected in the following metrics:

1. 1000 people are being discharged from hospitals to the community rather than institutions - a 1% shift in percentage discharges to community for those who need LTSS;
2. 500 people are transitioning to the community from qualified institutions and the State is on track to transition 850 persons per year;
3. The nursing home census is decreasing almost 1% every 6 weeks or 1500 people per year.

As previously discussed, the past 12 years have demonstrated significant progress towards the objectives of the BIP. Rebalancing goals were established by the LTC Planning Committee as early as 2003 and have been monitored annually ever since that date. The MFP Steering Committee, a key group of stakeholders including persons with disabilities, Executive Branch officials, elders, providers and others who have helped guide the process since 2000 when the Olmstead Task force was first created. The State recognizes the importance of a NWD/SEP as described in University of Connecticut's Long-Term Care Needs assessment completed in 2007. The report highlighted 'lack of knowledge about services' as the second leading obstacle to persons receiving community based LTSS. The State has implemented several initiatives to address the barrier. Most notably in 2007, the State received the first grant to fund the development of ADRCs advancing the State's concept of a NWD/SEP.

As referenced in the attached workplan, objectives of the BIP will advance as an integral part of the State's health care reform. The State is committed to a large systemic effort resulting in a web based single point of entry, equal access, standard assessments, and conflict free case management. All BIP partners are committed to expanding the current information and referral system into a system with town based local walk-in centers, web based access and a coordinated toll free call in center.

b. Current System's Strengths and Challenges: The State has provided a description of the existing LTSS information and referral, eligibility determination, and case management processes in the State.

The State's primary strength is its progress towards building an integrated data system for the delivery of healthcare, including Medicaid long-term services and supports. The system will coordinate affordable Care Act (ACA) initiatives including the BIP, the Health insurance Exchange, the new eligibility management system, and the modernization of eligibility operations. All systems are in advanced stages of preparation with many Advanced Planning Documents submitted and plans for implementation prior

to December 2015. The envisioned system is supported by a high level of automation where forms and submissions are web based, referrals are electronic, eligibility and service information including status is stored in an electronic 'My account' and data is shared electronically, with appropriate precautions, across departments. In addition, the State is in the final stages of updating its data warehouse. The warehouse revisions were designed with multiple users in mind, including LTSS users, and will support enhanced data collection, storing and reporting on Medicaid participants receiving LTSS.

The primary challenge of the current system is the extraordinary demands placed on the state agency partners to implement concurrent health reform initiatives.

Additional strengths and challenges are as follows:

Information and Referral

ADRC - Independent Living Centers, Area Agencies on Aging, Connecticut Community Care Incorporated provide walk in access on a regional basis and a toll-free call in center

The State has maximized coordination between the federally funded LTSS information and referral entities, specifically the Independent Living Centers and the Areas Agencies on Aging. In addition, the State has coordinated information and referral with Connecticut Community Care, the largest case management entity in Connecticut, as well as the State CHOICES program, the federally funded Connecticut State Health Information Program. Cross training and opportunities to build relationships as a result of both the Money Follows the Person Demonstration and the Aging Disability Resource Center grants have maximized capacity and led to greater understanding of aging and disability related cultures. In addition, all three entities provide information beyond Medicaid LTSS. Their strengths collectively lie in their relationships to and understanding of local supports and services and ability to connect people to supports that Medicaid does not provide such as self-advocacy, housing, legal services, etc. They also have a toll free call center with warm transfers between entities to assure that people receive the information that they need when they need it.

Town based entities provide walk in access at a local level

Other town based entities such as town social work agencies, senior centers, schools, and non-profits also have capacity and provide information and referral. Many have websites that include local resources.

Department of Rehabilitation Services (DORS)

DORS operates Connect-ability, the single point of entry for persons with disabilities seeking employment. Connect-ability offers a web based option for information as well as a toll free call in center. It also provides benefits counseling for persons with disabilities who have questions about how employment will affect their benefits.

Department of Developmental Services provides access to a central call center

The DDS help line handles X calls per day from persons either served by the DDS system or who are applying for services from DDS. Case managers offer information and referral and also offer assistance with navigating the DDS system.

2-1-1

The State's 2-1-1 system supports a toll free call center and a website with information regarding supports and services funded by the State. The searchable website is updated annually to assure that program information is reliable.

Long-Term Care Website

Maintained by the State's Commission on Aging, the Long-Term Care website links to the 2-1-1 site and offers key information targeted to persons who are seeking LTSS. The site includes information to assist with determining needs, finding housing, paying for services, planning for LTSS, etc.

The primary challenge of creating a strong information and referral network is building capacity at a town level and assuring standardization and consistency.

Eligibility Determination

Connecticut operates a coordinated system for financial and functional eligibility within the MFP unit and understands the importance of timely financial decisions as well as coordination with functional decisions especially as they relate to a rebalanced system. The MFP unit demonstrates and informs broad systemic change to the larger state system which is fragmented and confusing to persons who need LTSS. With this in mind, the MFP unit has been coordinating efforts with the DSS modernization initiative, ConneCT. ConneCT aims to modernize eligibility operations to improve client access, achieve better quality outcomes, enhance customer service, reduce costs, and provide a technology framework for the future. While the current financial eligibility process depends upon paper submission of required paperwork to DSS staff at a regional office or MFP centralized staff, the new system will depend upon electronic submissions, verifications, and requests for outstanding information viewable through a shared web portal. Responsibility for the current level 2 assessment process is currently not coordinated with financial eligibility. Case managers performing level 2 assessments,

other than MFP staff, have no direct, coordinated relationship with eligibility workers as they will under the new system.

Phase 1 of the new coordinated system scheduled for implementation by December 2012 involves 4 regional offices piloting Integrate Voice Response (IVR) call centers and migrating client accounts to a new worker portal. The 2nd phase of this process, set to roll-out in spring of 2013, includes launching three Benefits Enrollment Centers, an on-line financial screening for consumers, including LTC consumers, and centralized document management that entails scanning all documents and altering workflow to an electronic transfer and management of scanned items. The 3rd phase of the operational change includes on-line applications and redeterminations while the 4th phase includes web based integration of financial eligibility information with functional eligibility information. The web based prescreen functional eligibility feature will be piloted by MFP transition coordinators prior to implementation in ConneCT. Financial eligibility remains the responsibility of DSS staff while functional eligibility is conducted by DSS in coordination with several operating partners.

The current system level 2 screen is operated by entities as authorized under 1915C waivers. Connecticut has seven HCBS waivers. Each of the seven waivers has approved tools, methodologies and staff qualifications and eligibility is dependent upon prior categorical eligibility requirements as determined by the state plan for the aged, blind and/or disabled group. Each HCBS waiver uses a different functional eligibility criteria and tool. Of the seven waivers, only 2 have web based assessment tools and algorithms linked to budget allocations – the DDS waivers. While the State aims to have a new, web based comprehensive assessment tool linked to the data warehouse, reaching agreement on consolidation of tools and methodologies will be challenging.

Case Management

Most case management services in the State of Connecticut meet the criteria for conflict free case management as defined by the BIP. Case management is covered as an administrative function under the Medicaid State Plan and as a 1915C waiver for those who qualify. Persons who qualify for DDS or DMHAS services have access to targeted case management. Persons qualifying for the Acquired Brain Injury Waiver, the Katie Beckett Waiver, or the Elder waiver have case management covered under the respective waiver. Connecticut also offers intensive case management as an administrative function of its Administrative Services Organizations.

Case management especially as it relates to transitions between settings and services is a key focus for the State of Connecticut. There are several demonstrations within the State implementing various protocols for the purpose of developing best practice. In addition, the State's recent Medicare Medicaid Eligible Demonstration proposal sets out a plan for unprecedented coordination in care between medical and community services.

To assure that there are no conflicts within the case management services of the State, uniform standards reflecting the BIP requirements will be established. Assessments of each case management provider will be completed. Uniform standards for firewalls will

be established as well as compliance policies to assure transparency and protection of consumer interests by case managers.

c. NWD/SEP Agency Partners and Roles: The State has described the designated agencies that will likely comprise the SEP Agencies and has described the agency's anticipated role in the NWD/SEP system.

There several agencies coordinating efforts to develop a NWD/SEP/ADRC and expected to constitute the required infrastructure.

1. Oversight/Co-operating Agency - Department of Social Services (DSS), Division of Health Services (DHS)
2. Co-operating Agency – DSS, Bureau of Aging, Community, and Social Work Services;(Note: DSS Aging Division will become a stand-alone State Department on January 1, 2013)
3. Co-operating Agency – Department of Developmental Services
4. Co-operating Agency – Department of Mental Health and Addiction Service
5. Co-operating Agency – Department of Disability Services;
6. Town and regionally based entities including but not limited to existing ADRCs

Department of Social Services (DSS)

The DSS is the largest Department of the State responsible for administering Medicaid, multiple social service programs and benefits including the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families and the State Unit on Aging. DSS maintains a data warehouse which is linked to both the Eligibility Management System and to the State's medical claims system. The data warehouse provides the Department with analytic capability to measure impact of the various initiatives. As previously mentioned, the DSS is in the process of modernizing operations and increasing data integration in coordination with the Health Insurance Exchange. In coordination with the Health Insurance Exchange, DSS aims to build the Single Point of Entry for health care, programs and benefits, including persons who need assistance.

Oversight/ Co-operating DSS - Division of Health Services (DHS)

DHS is a large division of DSS with responsibility for administering and operating the State's Medicaid program, the MFP Demonstration, the Medicare – Medicaid Eligible Duals Demonstration, the Person Centered Medical Home initiative, the Pharmacy Program, the Dental Program, the Behavioral Health Program, the 1915C waivers and operating the Connecticut Home Program for Elders which includes the elder waiver. DHS will work to ensure timely implementation of essential infrastructure components required for the BIP, including development of the website and call center, physical SEPs at the local level, and the streamlined and coordinated processes of eligibility

determination, assessment, and service planning. As the oversight agency DHS will be involved in every aspect of the infrastructure development under the BIP. More specifically DHS is responsible for:

1. Administration of the Medicaid program;
2. Coordination with the Connecticut Department of Public Health;
3. Coordination with the State Health Insurance Exchange;
4. Coordination to develop and implement a Core Standardized Assessment tool and process for all Medicaid-eligible populations with LTSS;
5. Improving delivery of services coordination through creation of Person Centered Medical Homes, the Administrative Service Organizations for Behavioral Health and other Medicaid populations, and the proposed Medicare Medicaid Eligible Demonstration;
6. Funding and oversight of case management services and will assume responsibilities for policy development to ensure conflict free case management;
7. Funding and oversight of disability and mental health services for persons who qualify for medical assistance as well as services for elderly persons through the Connecticut Home Program for Elders;
8. Coordination of meetings related to implementation of the BIP and involvement of all stakeholders including people with disabilities and elders;
9. Oversight of the Medicaid Management Information System;
10. Development of qualifications for and quality oversight of NWD/SEPs/ADRC;
11. Coordinating development of NWD/SEPs/ADRC;
12. Coordination with DSS Division of Information Technology Services to integrate level 1 and level 2 functional screens with web based financial screens within the new ConneCT web based environment, to assure coordination with the new eligibility management system, and to assure coordination with the State's data warehouse.

DSS- DHS will play the lead role in the rebalancing of Medicaid-funded LTSS in favor of community living options to achieve the goal of an excess of 50% of LTSS expenditures on home and community based services by September 30, 2015. Major factors driving a steady increase in HCBS over institutionally based services include:

1. Connecticut's seven Section 1915 (c) waivers, along with consistent legislative support for rebalancing;
2. 1915(i) State Plan amendment providing services to elders not yet at nursing facility level of care;
3. Money Follows the Person initiative, which has helped 1270 persons with disabilities transition to the community since December 2008;
4. Implementation of the Informed Choice Protocol in Nursing Homes;

5. Implementation of the Strategic Rebalancing Plan building capacity at a local level to support demand for community LTSS and adjusting surplus of institutional beds;
6. The development and implementation of the mental health waiver in coordination with DMHAS;
7. Medicaid for Employed Persons with Disabilities;
8. Nursing home transitions under MDS Section Q;
9. The development and implementation of two new waivers for persons with Autism;
10. Policy changes such as the recent change in the Medical Practice Act allowing nurses to administer medication;
11. Improved nursing home level of care and Pre-Admission Resident Review process through partnership with ASCEND;
12. Initiatives aiming to change the culture of the State towards a person centered rather than a medical paradigm.

Co-Operating Division: DSS – Bureau of Aging, Community and Social Work Services, Aging Division – State Unit on Aging (Aging Division of DSS will become the Department on Aging January 1, 2013)

As Connecticut's State Unit on Aging, the Aging Division's responsibilities include coordinating all state activities related to the purposes of the Older Americans Act (OAA) and developing a State Plan on Aging. The Aging Division, anticipated to become a stand alone Department of the State on January 1, 2013, reviews plans submitted by the State's Area Agencies on Aging (AAAs), and is the conduit for federal funds distributed by the Administration on Aging under the OAA as well as State appropriated funds. The Aging Division works with the AAAs to promote expansion of home and community based services for elders in the State of Connecticut. Since 2007 the Aging Division has developed the ADRC in Connecticut by establishing a website in coordination with the Commission on Aging (www.ct.gov/longtermcare) for information and access to local LTSS and the establishment through three regional ADRCs. As previously mentioned, ADRCs in Connecticut are implemented through a partnership between AAAs, Independent Living Centers, and Connecticut Community Care Inc.

Co-Operating Division: DSS – Bureau of Aging, Community and Social Work Services, Division of Social Work Services

The Division of Social Work Services currently operates the Acquired Brain Injury Waiver and the Personal Care Assistance Waiver. With operational responsibilities for the waivers, social work staff is responsible for level 2 assessments, care planning, and case management.

Co-Operating Department: Department of Developmental Services (DDS)

DDS is responsible for determining eligibility for access to DDS services. Once an individual has been determined eligible functionally by DDS and financially by DSS, a case manager is assigned. Financial eligibility staff are co-located within DDS to assist with streamlining the process.

DDS is also responsible for the operation of two 1915C waivers. Operational responsibilities include level 2 assessments, development of care plans and ongoing delivery of services. In addition, DDS supports a toll-free help line to support families and persons with intellectual disabilities as they navigate the LTSS system. The help-line assists with completion of functional and financial eligibility applications and follow-up post application submission.

Co-Operating Department: Department of Mental Health and Addiction Services (DMHAS)

DMHAS is responsible for level 2 assessments for the mental health waiver. They are also responsible for care plan development, case management and plan implementation. Some services are subcontracted to Local Mental Health Authorities (LMHAs) across the state.

Co-Operating Department: Department of Rehabilitation Services (DORS)

DORS is responsible for assuring that employment is integrated into the NWD/SEP/ADRC. The DOR's Connect-Ability web site will be coordinated with the web based NWD/SEP/ADRC as will benefits and rehabilitation counseling. DORS will also have the lead in assuring that the level 1 and 2 functional assessment employment related questions.

Town or Regionally Based Entities

BIP operating agencies will establish local, qualified NWD/SEP/ADRC entities throughout Connecticut towns. Building from the strong foundation established by the DSS, Division on Aging, qualifying entities may range from ADRCs to Senior Centers to LMHAs or local municipal Social Work agencies. The partnering State departments will provide technical assistance, training, and establish qualifications, rules and procedures for the NWD/SEP/ADRC entities. Each qualifying NWD/SEP/ADRC will have access to the new DSS ConneCT system where information regarding status of both financial and functional eligibility will be documented in an individual's 'My Account'. In addition, qualifying entities will be provided with access to standardized level 1 functional assessment and to financial prescreen software so that they may assist persons at a local level who choose to have support with completion of web based forms either by phone or in person, rather than completing the forms independently.

As NWD/SEP/ADRCs, these entities will provide: 1) informational referral and access that includes Level 1 assessment; 2) referral for Level 2 assessment; 3) assistance with completion of eligibility application; 4) follow up to referred services.

d. NWD/SEP Person Flow: The State has provided an initial description of the planned "person flow" through the NWD/SEP system (i.e., the experience of the eligibility determination process from an individual's perspective, from start to finish), including how the State plans to coordinate functional and financial eligibility within the eligibility determination process and how these processes differ from the current system.

Planned Process: Initial information and referral

John Smith just celebrated his 85th birthday. His wife died 2 years ago and his children have become increasingly more concerned about the fact that he still lives alone. They have encouraged him to move to a smaller house but John is unwilling to leave the house where he and his wife raised their three children.

John and his wife were active in their church and community. They took good care of themselves and of each other. As evidence of this, they attended wellness meetings at the local AAA, now part of the ADRC. When John's diabetes grew worse, they attended meetings at the AAA on chronic disease management. After his wife died, John still attended meetings of interest when he could. The AAA was on the bus route which was helpful since now John is unable to drive.

Life was changing for John. He was unsteady on his feet and occasionally fell. His sight was becoming worse and he could no longer read without his magnifying glass. He struggled to read the computer screen. Even grocery shopping was becoming difficult. John felt comfortable discussing some of his concerns with friends at his church. They had seen the advertisements for the State's NWD/SEP/ADRC and told John that the State now has a web based option to help people navigate the service and support system and that they also have one to one assistance in each town. They told him that the AAA was part of a new network that may be able to help. Familiar with the AAA and how to navigate his way there on the bus, John decided to ask the AAA for help on Tues morning rather than using the web independently.

On Tuesday morning, John arrived at the AAA. Before long, he was meeting with a representative who told him about the new prescreening system in the State of Connecticut that could provide John with information about his eligibility for programs and services. She also told him about the new information and resource database that he or his family may be interested in viewing. The representative asked John if he would like to answer a few questions so that she could enter his information into the web based system. She assured John that his information would be safe and that his electronic files would be transmitted and stored with a unique identifier in a HIPAA compliant environment.

Level 1 Functional and Financial prescreen

John completed the pre-screen financial assessment which indicated that he is likely to be eligible for assistance from the State. Since he was likely eligible, the representative asked John if he would like to have assistance to complete the web based long-term care Medicaid application. John indicated that he would like assistance, including assistance with collecting required documents. The application was submitted online. The next step for John was completion of the pre-screen for functional needs. The representative assisted John with completing the web based pre-screen. The pre-screen indicated that he was likely eligible for elder waiver services. Since he was likely eligible, he had the option of submitting the form to request assignment of a level 2 assessment. John agreed to the assessment.

The representative had John sign the required paperwork before leaving so that she could assist with financial document collection and followed up with completing the application packet through submission of required documents within a few days. She also helped John set up his "My Account" so that he could view progress with his financial and functional applications on line. John was told to expect a call from a case manager at Connecticut Community Care Inc (CCCI) within 2 weeks.

Level 2 Functional Assessment

John received a call from CCCI within 3 days and the assessment appointment was set up. The assessment was web based and took about 2 hours. After the assessment, John was told that he was eligible for services and that the case manager would need a few weeks to determine his individual budget. After establishing the budget, she planned to revisit John so that they could develop the care plan together.

"My Account" Coordination of Financial and Functional Determinations

A few days later, John received a call from the representative at the AAA. She had received an auto message on John's "My Account" prompting her to log into the secure system. John also received an auto message but he didn't check his email often and didn't realize there was a notice waiting for him. After logging in, she learned that DSS had received all of the required documentation for his Medicaid eligibility. She also told him that there appeared to be no outstanding information required for his application for services under the elder waiver. She reminded John about how he could track progress independently through "My Accounts".

Service Plan Development

The CCCI case manager called John with good news about his budget and arranged for a visit to his home. Together they decided the best mix of services designed to meet his needs. The CCCI case manager accessed the new information and resource web site to help John understand what kinds of services are available and what the benefits may be of each. John chose his services with support from the case manager. The plan was submitted to DSS for approval.

Financial and Functional Approvals

By about 30 days after John's initial visit with the AAA, his "My Account" reflected approvals for both Medicaid LTC and the elder waiver services. His plan services were

initiated the day after financial approval and his CCCI case manager continued to support him during the coming months.

How this differs from the existing process:

Connecticut is exploring the process described in the above example. Increasing access to community LTSS through a streamlined NWD/SEP/ADRC is key to assuring that people who need LTSS have the option of community living. Without the system described above, people in Connecticut will be unnecessarily institutionalized with no community service plan, no payer source, or both.

The process addresses the following gaps:

1. New web based single point of entry;
2. Improved eligibility workflow through electronic imaging and filing under ConneCT;
3. Establishment of "My Account" function offering people the maximum independence in obtaining their account status and to assure coordination and communication between functional and financial procedures;
4. Consolidation of existing information and resource databases to support people in understanding service options;
5. Coordinated toll-free phone number building off of the existing toll-free number established by the Division on Aging;
6. New global communications campaign to raise awareness about the new resources;
7. Web based financial pre-screen and application for financial assistance;
8. Web based functional level 1 and level 2 assessment;
9. Web based level 2 assessment integrated with the eligibility management system;
10. One to one assistance with navigating the process, accessible within each town;

e. NWD/SEP Data Flow: The State has provided a discussion of the data flow within the eligibility determination process and has described where functional and financial assessment data will be housed and how they will be accessed by SEP Agencies to make eligibility determinations.

Financial applications for assistance will enter the workflow either through electronic submission or through the DSS document scanning center. Applications will be assigned a unique identifier and will be stored in the new web based "ConneCT". The unique identifier will establish the electronic file in which any other documents pertaining to the application will be stored. The file will include eligibility statuses such as requested documents or documents received as well as eligibility decisions. The file will be accessible through the "My Accounts" function to assure coordination and

communication. In general, ConneCT will store all documents that would have otherwise been paper. Data relative to the documents will be entered into the new Eligibility Management System where financial determinations are made based on data entry from the documents. Data from the Eligibility Management System are transmitted to the DSS data warehouse. The data warehouse also stores claims data and supports analytic functions for DSS. While SEP town level partners would not have access to the data warehouse, they will have access to the Eligibility Management System or to the ConneCT system so that they can assist the person with navigating the system.

Data from DDS functional assessments currently are integrated with DDS budget allocation system but are not integrated with the DSS data warehouse. Other level 2 waiver functional assessments are currently not web based. The intent under the BIP is to integrate level 2 assessment information with the ConneCT system and the Eligibility Management system and to store key data relative to the assessment, such as level of need, in the data warehouse. This will give the State the ability to understand allocation of LTSS funds across all LTSS participants according to level of need. Standardization of level determination across all populations is a priority whether accomplished through an implementation of a common tool or through a crosswalk.

f. Potential Automation of Initial Assessment: The State has described potential opportunities for and challenges of automating the initial assessment tool via the NSD/SEP website.

The State has two major initiatives in advanced stages of planning focused on data integration and electronic files. Initial discussions in the State point to the opportunity to coordinate with the work being done for the Health Insurance Exchange and the DSS ConneCT. The initial financial assessment for Medicaid is already completed and ready for roll-out. The initial functional prescreen will be built as part of the system with auto-referrals made to level 2 case managers for those who are found 'likely eligible' based on the level 1 screen. This work is viewed as part of the scope of the larger systemic changes.

The potential challenge of integrating with the larger initiative is the risk of delays if problems with the large scale change are encountered.

g. Potential Automation of the Core Standardized Assessment: The State has described potential opportunities for and challenges of automating a CSA/functional assessment tool. Automation includes, at a minimum, real time electronic collection of functional assessment data.

As previously mentioned, DDS has been using an automated level 2 assessment tool for several years and is currently in the process of developing a web based case management system as well as web based Individual Plans. The DDS plan includes a requirement for

the architecture to accommodate additional 1915C waivers. While the two waivers operated by DDS use the same assessment tool, all other waivers use different tools designed for the different populations served by the waiver.

Automation of the CSA/functional assessment tool is a priority so that data can be collected and analyzed as our LTSS user population grows over the next 10 years. While there has been no final decision regarding a single CSA, the State will advance discussions over the next few months and will at a minimum have web based assessment tools that cross walk to a single standardized level of need indicator.

h. Incorporation of a CSA in the Eligibility Determination Process: The State has described the current functional assessment instruments and processes used to determine eligibility for LTSS. Does the State currently use a single CSA for all LTSS populations? If not, how might the State incorporate a CSA into its current process? What would be the major challenges to adopting a CSA? What technical assistance might the State need to make this happen?

Current Functional Assessment Instruments and Processes

As previously mentioned, Connecticut does not use a single CSA for all LTSS. A variety of assessment tools are used in Connecticut depending on DHS requirements and service provider types. While home health providers utilize the OASIS, waiver case managers utilize a total of 6 different assessment instruments. The State may need technical assistance to demonstrate how other states navigated similar changes and how the changes benefited the overall design of LTSS systems.

Incorporation of the CSA into Current Processes

1. A standard CSA tool will be researched;
2. Stakeholder meetings with waiver managers and home health agencies will be facilitated;
3. Consensus on CSA will be sought;
    a. the State recognizes that total replacement of all assessment tools and adoption of a new tool by September 2015 may not be feasible;
    b. the State commits to combining tools for target populations advancing towards a CSA where feasible;
    c. the State commits to all tools meeting the requirements of a CSA and developing a cross walk.
4. Rules and requirements will be established related to use of the tool, administering the tool, management of the process, and staff qualifications and supervision.
5. Training related to the use of the tool will be established.

6. Data from assessment tools will be stored in the data warehouse so that analytics based on standardized level of need can be performed.

i. Staff Qualifications and Training: The State has discussed considerations related to staff qualifications and training for administering the functional assessment.

DHS will establish annual credentialing requirements for staff at local NWD/SEP/ADRC to demonstrate competencies with Medicaid financial and functional eligibility requirements and level 1 assessments. Training will be developed and implemented on a regular basis to assist staff with meeting the credentialing requirements. The State envisions web based testing modules.

Level 2 assessments will continue to be conducted by the entities authorized either under a 1915C waiver or the Medicaid State Plan. The State does not intend to seek amendments to change approved qualifications and licensure requirements.

j. Location of SEP Agencies: The State has provided a discussion of the issue of access to physical SEP agency locations. How will the State ensure access to physical SEP agency locations? What share of the State's population is likely to live within the service area of at least one SEP? (Rough estimates are acceptable.) What will the State do to maximize the share of the State's population living within the service are of at least one SEP? How will the State arrange evaluation services for individuals who do not live within the service area of any SEPs? How will the State ensure that these physical locations are accessible by older adults and individuals with disabilities requiring public transportation?

The State's Strategic Rebalancing Plan calls for the development of town based continuums of care. To support this vision, LTSS supply and demand estimates have been developed by town. The data will target priority areas for development of community LTSS and for towns where there is a surplus of institutional beds. Consistent with the vision, Connecticut envisions a physical NWD/SEP/ADRC entry point in every town. The site could be a senior center, a library, or a town social work office. To become a NWD/SEP/ADRC site, there will be required training and credentialing. The web based NWD/SEP/ADRC site will provide guidance to the local entities and provide the needed standardization across the state. All sites will be accessible and on a bus route when possible. Computer access terminals will be located in common places within towns such as pharmacies. For towns that do not have public transportation or for persons who cannot travel to the town based access point, call in centers will be available or home visits will be possible. 100% of persons seeking services in Connecticut will have access.

k. Outreach and Advertising: The State has described plans for advertising the NWD/SEP system.

A global communication plan is currently under development for the State's NWD/SEP/ADRC system. The communication plan includes radio, print, and billboard advertisements. In addition, the plan anticipates the creation of a speaker's bureau. The State plans to coordinate the global communication plan with the Workforce Development Plan.

More specifically the plan calls for:

1. Outreach to existing ADRCs, new town entities and regional entities regarding new process and tools;
2. Outreach materials at bus stations, grocery stores and pharmacies, etc.;
3. Public outreach campaign to community groups such as churches and senior centers;
4. Town meetings;
5. Training and outreach to DSS, DDS, DMHAS, and DORS case management staff;
6. Presentations to relevant councils, task forces, committees, etc.

l. Funding Plan: The State has provided a discussion of anticipated funding sources to support the requirements of Balancing Incentive Program, including development of a NWD/SEP system and use of CSA.

Money Follows the Person Demonstration

The State plans to utilize administrative funding under the MFP Demonstration to support BIP requirements. Some components of the BIP have already been approved such as co-location of eligibility staff. Connecticut plans to submit an additional request for administrative funds to support BIP requirements.

Medicaid Management information Systems (MMIS)

Many of the objectives of the BIP are consistent with other Medicaid Modernization efforts; therefore, the State plans to coordinate efforts and plans to seek 90% match on qualifying expenditures not covered by MFP.

Aging and Disability Resource Center Grant Funding

The State just received an ADRC grant and plans to coordinate the BIP with the ADRC expansion to maximize impact.

m. Challenges: The State has provided a discussion of the characteristics of the State's current system of LTSS that might present barriers to rebalancing.

Connecticut's Long-term Care Plan has identified challenges to rebalancing for the last 13 years. Departments have addressed key challenges through strategic interventions either funded through grants or through Connecticut State general revenue. Over the past 30 months, the DHS has focused on the development of a Strategic Rebalancing plan. The plan includes a utilization and cost model which focuses on town-specific data. Data from various sources will be incorporated into the initial model and updated on a semiannual basis. This model will be used to project supply and demand for LTSS at a town level. More specifically, it will identify areas of the state where there is an excess of NF beds, areas where there may not be enough beds, and areas where transitional programs and additional community LTSS are needed. The model will extrapolate trends within towns at a sufficient level of detail so that supply and demand of specific services such as personal care attendants, transportation or housing will be readily identifiable. Based on the principle of choice, the model assumes that barriers preventing choice in where Medicaid recipients receive LTSS are removed. It will serve as an important tool guiding decisions regarding investments in LTSS moving forward.

The plan identifies procedural, capacity and policy challenges (barriers) driving costs and resulting in unnecessary institutionalization must be addressed. Barriers include:

- Lack of sufficient services, supply, and information about home and community-based services (HCBS),
- Inadequate support for self-direction and person-centered planning,
- Lack of housing and transportation,
- Lack of a streamlined process for hospital discharges to the community rather than nursing homes for persons requiring LTSS,
- Lengthy process for accessing Medicaid as a payer, and
- Lack of a sufficient workforce

Lack of sufficient services, supply, and information about home and community-based services (HCBS),

. Lack of information

As previously mentioned, the University of Connecticut 2007 Long-Term Care Needs Assessment found that lack of knowledge regarding LTSS was the second leading obstacle to people receiving community based LTSS. Respondents to the survey stated that it should be easier to know what services are available and how to access them. Without comprehensive information about existing community-based options, people may see nursing homes or other residential care as their only option. The leading obstacle sited by the study indicated that people needed financial assistance to pay for LTSS. In many cases there was a misunderstanding about what Medicare covered; in fact, people thought that Medicare would pay for LTSS.

. Lack of supply

Without adequate supply of services funded by the State, people needing services may be left with institutional care as the only option. While Connecticut has a 'no waiting list' policy for elder services, 1915C waivers for people under the age of 65 have caps and often have waiting lists. Balancing the need for LTSS with budgetary concerns is a challenge for the State.

. Lack of services - standardization
The current LTSS system of the State is fragmented and confusing. There are multiple waivers each with different services and rates for services, cost caps, eligibility rules, assessment tools and methodologies. The lack of standardization across the system leads to inequities in the manner in which different target populations experience the service delivery system.

Inadequate support for self-direction and person-centered planning,
Connecticut has self-directed personal care assistance (PCA) in each of its 1915C waivers. The last waiver to add PCA was the elder waiver in 2010. While now it is possible for elders to self-direct, there are inconsistencies in how the service option is presented. Person-centered planning is a foundational philosophical element in all of LTSS but once again there are inconsistencies in how the philosophy is implemented. The system is challenged to shift from a culture of taking care of people to empowering people to take care of themselves through informed choice. The balance between safety and risk and the role of government is ongoing.

Lack of housing and transportation,

Housing
Provision of affordable, safe and accessible housing plays a critical role as Connecticut assists Medicaid consumers to either remain in or return to the community. Appropriate housing opportunities for HCBS consumers can vary greatly and are frequently the primary barrier for LTSS consumers to receive HCBS. In order for the State to accomplish its LTSS right-sizing goals, it will be necessary to have an adequate supply of housing so the established rebalancing targets may be accomplished.

Housing options include a person's own home (owned, leased, or shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes (rest homes). Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community. Key to the State's strategy is the establishment of a Medicaid housing plus supports specialist to assure coordination between the Department of Housing and Medicaid LTSS.

Transportation

Transportation becomes central in providing Medicaid consumers' access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers in order to provide the care needed for consumers to successfully remain in or return to the community. Frequently acknowledged as one of the greater unmet needs in communities, it is frequently not accessible or affordable.

Lack of a streamlined process for hospital discharges to the community rather than nursing homes for persons requiring LTSS,

Hospital discharge planning activities often drive patients to NFs in order to provide a safe discharge environment and act as an effective mechanism in transitioning consumers along the continuum of care to ensure that they receive the appropriate follow-up care and services they require. For Medicaid participants discharged from a hospital to a nursing home, the risk of long-term institutionalization is significant. Data shows that 65% of all Medicaid participants who enter NFs are still there after six months.[1] Thus, for vulnerable populations, entry into a NF can often lead to permanent institutionalization and loss of community ties and individual freedom of choice. Additionally, health services research indicates NFs could provide viable alternatives to acute inpatient admissions/re-admissions, effectively bypassing emergency departments (EDs) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can help to ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into the community.

Barriers that impact discharges from both nursing facilities and hospitals are addressed in this strategic plan. The primary barriers include lack of streamlined access to community supports, lack of standardized process for transitions between care settings, and lack of an expedited eligibility process. Key strategies in this plan focus on the establishment of a single point of entry that will result in quick linkages to community LTSS and transitional services and supports under MFP.

Lengthy process for accessing Medicaid as a payer,

The eligibility process for long-term care Medicaid is challenging in the State. During a recent forum, hospital discharge planners cited lack of payer for LTSS upon discharge as the primary reason that they discharge to nursing homes. It is routine for nursing homes to accept persons with Medicare as a payer and who then spend down to Medicaid while in the nursing home. Approximately 14% of the persons who apply to MFP are pending Medicaid eligibility. Their discharge is delayed pending Medicaid approval. The length of process time directly relates to unnecessary nursing home costs which are approximately two third more costly than community care plan costs. Lack timely process results in unnecessary institutionalization and unnecessary cost.

Lack of a sufficient workforce

As the State begins to operationalize its efforts to right-size its LTSS services between NFs and HCBS, there are many important issues to consider. Chief among them is assessing the workforce capacity as a result of rebalancing the delivery system. As demand for HCBS increases, the demand for paid and unpaid direct care workers will also increase. Between 2006 and 2030, the population over the age of 65 is expected to increase by 64%, while the working-age population is expected to decrease by 2%. This

[1] Connecticut Commission on Aging Strategy Paper, December 2010, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fcoa%2FPDFs%2FFact%2520Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nqhsWUNuxCZBopnlQ, last accessed December 9, 2011.

gap will decrease the supply of informal caregivers as well as the pool of direct care workers. Understanding and leveraging the informal caregiver supply while making the direct care field an attractive option for job seekers is a key component of LTSS right-sizing. As Connecticut aggressively pursues Medicaid rebalancing goals, the need for focused efforts to recruit, train, retain and support paid and unpaid caregivers is essential. Without a focused, coordinated approach, lack of caregivers will stall rebalancing efforts and Connecticut will fail to meet its goals. The State will begin its strategic approach by developing a comprehensive workforce development communication plan.

n. NWD/SEPs Effect on Rebalancing: The State has discussed how the NWD/SEP system will help the State achieve rebalancing goals.

As previously mentioned, Connecticut has a Strategic Rebalancing Plan with specific strategies, tactics and metrics. The NWD/SEP/ADRC is an essential part of the plan.

Without access to information about supports and services, the people of the State of CT cannot possibly make an informed decision regarding LTSS. Informed choice and decision making is part of the vision of the State and therefore a guiding parameter of all systems development. A rebalanced system must have a way for people to access information.

Accessing information sounds simple but in fact, it is very complex. The rules, policies, procedures and programs comprising the LTSS system are very complicated and not easy to navigate. For this reason, a primary tactic of Connecticut's Strategic Rebalancing plan is the creation of a comprehensive web based single point of entry coordinated with other health care initiatives of the state. The system will be easy to navigate and give people access to the information that they need regarding both financial and functional eligibility. It will also give people access to their applications as well as status updates and information needed for eligibility determinations. It should be noted that Connecticut is also in the process of developing an expedited eligibility process. The process improvement is coordinated with the development of the NWD/SEP/ADRC. The goal of the system is to connect people to services in a seamless manner. While the system will make it easier for people to navigate the system independently, it will also support state agency staff and others involved in the SEP/NWD/ADRC as a primary communication tool. Persons involved in assessments or in development of care plan will have immediate access to status of financial eligibility as will support staff assisting with one to one navigation. Persons involved in financial eligibility will have access to the functional process and status. The desired outcome is a coordinated entry point for both staff and for the people served by the system. Connecticut's entry point is called ConneCT. A rebalanced system must have a way for people choosing community LTSS to connect quickly with services and to avoid institutionalization.

Linked to the ConneCT system will be a central data base of information regarding LTSS beyond what DHS administers. Many focus groups hosted over past few months have indicated that people need access to State supports but also local supports; coordination at a local level is imperative. This will be seamless to the user and will be the database that connects all State level services with local level services, an important part of a single point of entry.

The availability of the new process through ConneCT and the new comprehensive services data base is meaningless without advertising. For this reason, the State plans to engage in a global communication plan raising awareness of community based LTSS and also raising awareness about the SEP/NWD/ADRC.

While consumers and caregivers need information and a streamlined means of accessing supports, the State needs a means of comparing utilization and expenditures across populations. Standardizing assessment is the key first strategy in creating parity across age and disability and assuring fiscal controls supporting comparative analysis across the various LTSS settings, including nursing homes. Standardizing assessment will result in standard levels of need which will be linked to standard budget allocations. Needs assessment data will be linked to the Medicaid Management Information System so that level of need data, individual budgets and expenses across LTSS can be analyzed easily with common metrics. A rebalanced system must have equitable allocation methodologies which are dependent upon a common standardized assessment.

With a common core needs assessment and stronger financial controls in place, the State can begin to explore some of the fragmentation that exists within the community LTSS. The strategic plan explores development and implementation of multiple options that may address some of the inequity between services that existing in the State today.

o. Other Balancing initiatives: The State has described other current initiatives in which it is currently involved that share similar goals and requirements as the Balancing Incentive Program. The State has described any more general commitment made toward rebalancing LTSS.

The Money Follows the Person Rebalancing Demonstration hosted a forum on rebalancing the State's LTSS on November 29, 2011. As a direct result, a strategic plan was developed and is now in its first year of implementation. The State's Strategic Plan for Rebalancing covers State Fiscal Year 2013 through 2015 and focuses on 4 key strategic areas: home and community based services; housing and transportation; institutional transitions including nursing homes and hospitals; workforce development; nursing home modernization and diversification. Key metrics guiding the plan include supply and demand projections for LTSS at a town level through 2025. The supply and demand projections consider the impact of interventions such as MFP on the percentage of LTSS participants choosing home and community based services rather than institutional services. Data projections reflect institutional bed surplus, workforce needs, nursing home census and other data for each of Connecticut's towns. Strategies, tactics and metrics associated with the plan are located in Appendix A, "STRATEGIC REBALANCING PLAN: A PLAN TO REBALANCE LONG TERM SERVICES AND SUPPORTS 2013 - 2015".

p. Technical Assistance: The State has described anticipated technical assistance needs to achieve rebalancing.

The State of CT is anticipating the need for technical assistance with the development of a web based CSA. The community LTSS system currently utilizes multiple tools and multiple assessment methodologies. With the exception of DDS, all forms are paper based. As stated previously, standardization is key as Connecticut expands supply of HCBS. It would helpful to learn about best practices in other states and how they navigated the change to a common standardized tool. In addition, it would be helpful to learn about how the assessment is integrated with state data systems and any analytics they may have to monitor their HCBS systems.

Financial Reporting Form

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Balancing Incentive Payments Program (Balancing Incentive Program) Applicant Funding Estimates

Long Term Services and Supports

State	Connecticut
Agency Name	Department of Social Services
Quarter Ended	
Year of Service (1-4)	FFY 2013-2015

State FMAP Rate	50%
Extra Balancing Incentive Program Portion (2 or 5%)	2%

					Projected LTSS Spending*			
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded by Balancing Incentive Program (3 year total)	*Year 1 (Jan 13-Sep 13)*	*Year 2 (Oct 13-Sep 14)*	*Year 3 (Oct 14-Sep15)*	
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	
Line 12 - Home Health	776,930,676	388,465,338	388,465,338		194,754,561	280,197,571	301,978,544	
Line 19B - Home & Community 1915i Only	11,019,062	5,509,531	5,509,531	11,019,062	2,914,351	3,992,469	4,112,243	
Line 19A - Home & Community	2,818,918,495	1,409,459,248	1,409,459,248		729,699,162	1,013,917,422	1,075,301,911	
DMR WAIVER II (ISF)	278,040,034	139,020,017	139,020,017		75,397,586	101,231,007	101,411,441	
CHC WAIVERED SVCS	547,231,158	273,615,579	273,615,579	3,237,443	132,828,554	196,452,861	217,949,743	
DMR WAIVER	-	-	-		-	-	-	
MODEL WAIVER	78,942	39,471	39,471		20,826	28,641	29,475	
PCA WAIVER	92,483,990	46,241,995	46,241,995	14,445,000	21,700,617	31,249,244	39,534,129	
ABI WAIVER	136,926,490	68,463,245	68,463,245	18,900,000	33,787,763	47,037,588	56,101,139	
COMP DMR WAIVER	1,725,602,093	862,801,046	862,801,046	15,000,000	456,351,502	624,568,825	644,681,766	
MH WAIVER	14,985,134	7,492,567	7,492,567	10,179,000	2,687,666	5,034,048	7,263,420	
DDS Employ Day Supp	17,200,529	8,600,264	8,600,264		4,687,857	6,250,476	6,262,196	
AUTISM WAIVER	6,370,126	3,185,063	3,185,063		2,236,791	2,064,732	2,068,603	
Line 24A - Targeted Case Management	32,157,006	16,078,503	16,078,503		9,353,484	11,751,314	11,052,208	
Money Follows the Person (MFP) Services	104,688,775	75,800,651	28,888,124	N/A	21,530,016	40,372,184	42,786,576	
Demonstration Svcs	883,902	662,927	220,976		240,900	321,200	321,802	
Supplemental Svcs	10,863,721	5,431,860	5,431,860		3,044,553	3,905,922	3,913,246	
Qualified Svcs	92,941,152	69,705,864	23,235,288		18,244,563	36,145,062	38,551,528	
TOTALS	3,743,714,015	1,895,313,271	1,848,400,744	72,780,505	958,251,574	1,350,230,959	1,435,231,482	

*Total Service Expenditures include all projected expenditures for each FFY (PY01, PY02, PY03 and adjustments).

*MFP Services excluded from additional 2% FMAP and in column D.

DRAFT

STRATEGIC REBALANCING PLAN: A PLAN TO REBALANCE LONG TERM SERVICES AND SUPPORTS

2013 - 2015

State of Connecticut
Department of Social services
November 1, 2012

CONTENTS

1

Introduction

The State of Connecticut (State) is committed to creating a more efficient and effective long-term services and supports (LTSS) system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need LTSS to choose whether they want to receive these services in a nursing facility (NF) or in a community setting. In order to attain the vision of enhanced qualify of life and increased choice for individuals across all disabilities to live, work and age within their own communities, the concept of a town-based LTSS compendium was developed. Honoring the autonomy and local governance authority of the towns within Connecticut, the individually tailored, town-based approach to LTSS will provide choices ranging from various types of supportive housing options to care provided in a nursing facility; these options will reflect the preferences of the persons they are designed to serve and support a seamless transition from hospital to short-term rehabilitation and back into the community.

Design and implementation of a strategic plan within the time frame anticipated by this plan is imperative given that over the next several years the number of people estimated to need LTSS will increase dramatically due to the aging population. According to the U.S. Administration on Aging's Profile of Older Americans[1], the number of people age 65 and older is expected to grow to 19.3% of the population by 2030, marking a significant growth in the portion of this population nationally. This trend is even more compelling in Connecticut, where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025.[2] Notably, in the November 2011 report entitled *90+ in the United States: 2006-2008*[3], Connecticut ranked second among states with the highest percentage of the population in both the 'Aged 90 and Over' and 'Aged 65 and Over' categories. The report also notes that age is positively associated with incidence of physical limitations, and the oldest have the highest levels of physical and cognitive disability. By 2025, more than 64,000 individuals in Connecticut are expected to need Medicaid LTSS – an increase of more than 24,000 individuals over current levels[4]. Estimating future demand, building sufficient supply with quality

[1] U.S. Department of Health and Human Services Administration on Aging. A Profile of Older Americans: 2010 (updated February 25, 2011).

[2] Connecticut Long Term Care Planning Committee, "Long Term Care Plan: A Report to the General Assembly", January 2010, page 42, table 5.

[3] Wan He and Mark N. Muenchrath, US Census Bureau, American Community Survey Reports, ACS-17, *90+ in the United States: 2006-2008*, U.S. Government Printing Office, Washington, DC, 2011.

[4] Medicaid Long Term Care Services and Supports Utilization and Cost Projection Model, State of Connecticut – Department of Social Services. November 30, 2011.

assurances, and eliminating policy and procedural barriers that prevent choice are all key to the State's Strategic Rebalancing Plan.

The projected increase in the aging population is especially relevant to the design of benefit and eligibility in the State's Medicaid program. Since 42% of the costs associated with LTSS in Connecticut are paid by the Medicaid program, it is essential that the Medicaid LTSS cost structures be modified with the aim of not only assuring choice, but also controlling costs. In SFY 2009, Connecticut spent 65% of its Medicaid LTSS dollars on institutional care for individuals who are aging and individuals with disabilities.[5] A 2011 analysis of adults age 31 and over using Medicaid LTSS shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and 2008: total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older.[6] The State's high utilization of nursing homes for persons receiving LTSS is a statistic that stands in contrast to surveys completed by LTSS users where 75% indicate their preference for services in the community.[7] In addition, the average cost of serving a Medicaid participant in the community is approximately one third[8] of the average cost of serving someone in an institution. Serving people in the community when it is preferred, safe and on average more cost effective, will result in more people served for each LTSS dollar spent. Procedural, capacity and policy barriers driving costs and resulting in unnecessary institutionalization must be addressed. Barriers include:

- Lack of sufficient services, supply, and information about home and community-based services (HCBS),
- Inadequate support for self-direction and person-centered planning,
- Lack of housing and transportation,
- Lack of a streamlined process for hospital discharges to the community rather than nursing homes for persons requiring LTSS,
- Lengthy process for accessing Medicaid as a payer, and
- Lack of a sufficient workforce

It is essential that the Strategic plan address the aforementioned barriers in order to advance true choice regarding where persons receive their LTSS as well as more efficient distribution of LTSS dollars. The report that follows details specific strategies that are intended to support this result.

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[5] Connecticut Long Term Care Planning Committee; Long Term Care Plan: A Report to the General Assembly; January 2010; p. 54, Table 15.

[6] *American Journal of Public Health*, September 2011, Vol. 101, No. 9; "Relations Among Home- and Community-Based Services Investment and Nursing Home Rates of Use for Working-Age and Older Adults: As State-Level Analysis", Nancy A. Miller, PhD.

[7] "Raising Expectations, A State Scorecard on LongTerm Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers" September 2011, Susan C. Renhard, Enid Kassner, Ari Houser, and Robert Mollica, p. 1. AARP Public Policy Institute

[8] Across the States, Profiles of Long-Term Services and Supports, Executive Summary, State Data, and Rankings, Ninth Edition, 2012, Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, p.14 AARP Public Policy Institute

It is also essential for the strategic plan to continually evaluate and estimate the impact that the strategic initiatives have on supply of both HCBS as well as institutional services. The plan aims to evaluate supply and demand trends and projections every 6 months. The current model detailed in Section 2 of this report projects a surplus of 5,000 institutional beds assuming barriers that prevent choice are removed. As demand for institutional care decreases, the plan details a proactive approach to reducing unneeded beds and building community capacity. Key strategies focus on partnerships with institutional providers who are interested in diversifying their business models to provide community LTSS where need is identified in town level supply and demand data maps. The State's strategic plan includes competitive procurements targeted to institutional providers for the purpose of building community LTSS which reflect the needs and preferences of the town.

Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the November 2011 Long-Term Care Right-Sizing Strategic Planning Retreat, the State has sought the input and expertise of those interested in building a sustainable LTSS system within the state. Stakeholders participating in the strategic planning process included individuals with LTSS needs, family members, advocates, ombudsmen, State staff, providers (community and institutional), Money Follows the Person Steering Committee members, academics and others. Recommendations from the right-sizing retreat (Appendix B) provided a foundation on which this plan was developed. With an unprecedented level of partnership and collective work toward the common goals, stakeholders will continue to play a key role in the implementation and evaluation of LTSS strategic initiatives.

The plan, guided by the vision of choice, autonomy and dignity for the people we serve, aims to achieve a rebalanced system by: 1) removing barriers that prevent choice in where people receive LTSS at a state policy and systems level; and 2) partnering with nursing homes, communities, and existing community providers to implement change at a local level. **After careful review, the recommendations included in this document were selected to comprise the first phase of Connecticut's Right-Sizing Plan based on considerations related to the timing, resources and funding necessary to complete each strategy.**

2

Utilization & cost-projection model for Medicaid long-term services and supports

Estimating future demand for Medicaid LTSS and funding appropriate supply is a critical component of Connecticut's Strategic Right-Sizing Plan. Future demand projections are based both on existing trends in distribution of LTSS dollars and preferences between institutional and HCBS settings as well as assumptions about future trends. Future trend assumptions take into consideration the impact of the various strategies and tactics outlined in this plan. As barriers that prevent choice are eliminated, it is assumed that there will be an exponential shift towards HCBS LTSS. This shift is reflected in the models.

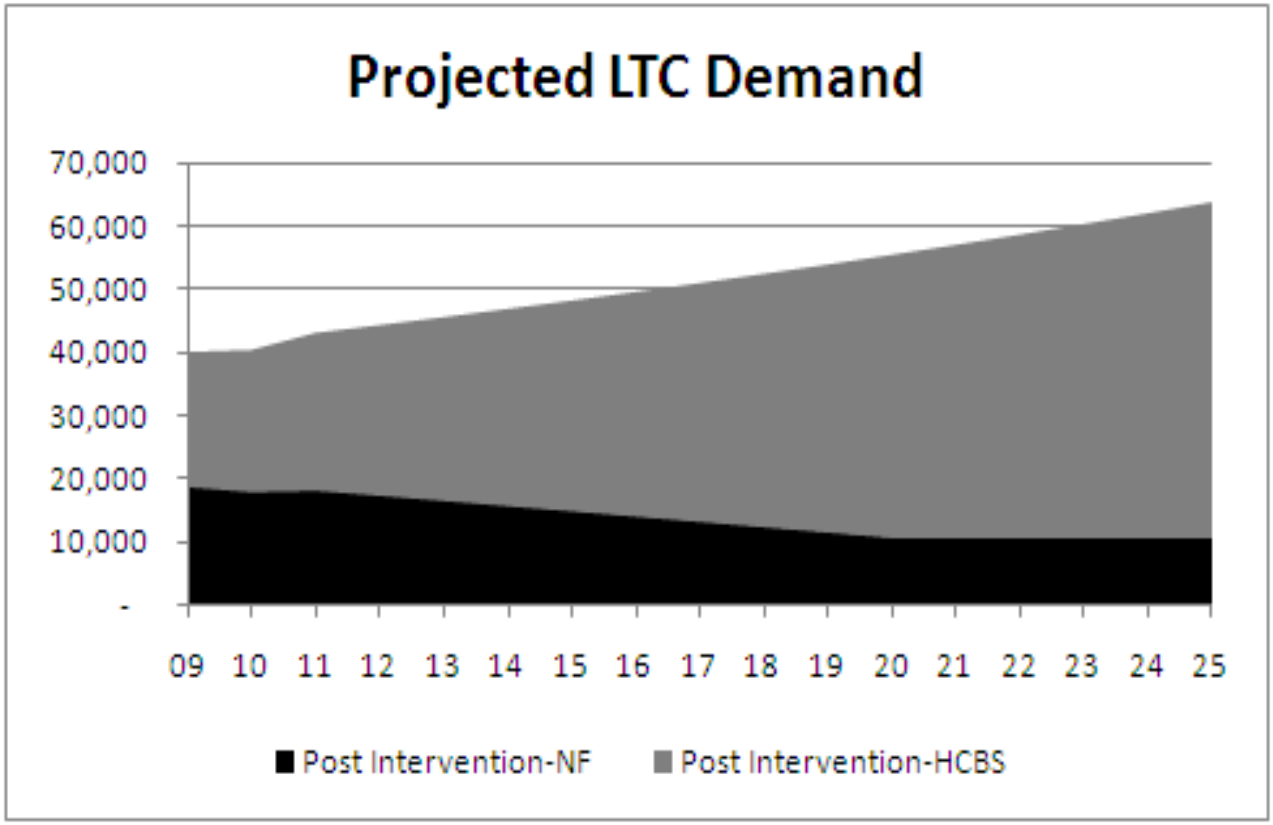
Modeling includes two key elements: First, a high-level review, which uses readily-summarized data from the American Community Survey as well as the historical Medicaid NF and HCBS participant information from state fiscal year 2004 to the present from the State's Office of Policy and Management.

The high-level review includes three steps:

- Projecting the overall demand for LTSS
- Examining the effect over time to the HCBS/NF mix if existing trends persist absent the impact of any new initiatives
- Factoring in the impact to the HCBS/NF mix if existing initiatives accelerate or new ones are introduced.

The following graph displays the projected growth of the total demand for Medicaid LTSS in Connecticut as well as the expected change in the mix between HCBS and NF services. While the demand for LTSS is expected to grow to more than 64,000 users in 2025, the mix between HCBS and NF services is expected to move from the current HCBS/NF mix of 53%/47% to 83%/17% in 2025.[9] Changes in the HCBS/NF mix are largely attributed to interventions funded by the State's Money Follows the Person (MFP) rebalancing demonstration. Interventions are designed to eliminate barriers which prevent choice in where users receive their LTSS.

[9] Ibid.



The second element of the utilization and cost model focuses on town-specific data. Data from various sources will be incorporated into the initial model and updated on a semiannual basis. This model will be used to project supply and demand for LTSS at a town level. More specifically, it will identify areas of the state where there is an excess of NF beds, areas where there may not be enough beds, and areas where transitional programs and additional community LTSS are needed. The model will extrapolate trends within towns at a sufficient level of detail so that supply and demand of specific services such as personal care attendants, transportation or housing will be readily identifiable. Based on the principle of choice, the model assumes that barriers preventing choice in where Medicaid recipients receive LTSS are removed. It will serve as an important tool guiding decisions regarding investments in LTSS moving forward.

3

Strategies for right-sizing

Home- and community-based services options

Overview

The strategies outlined below represent key steps to improve the home- and community-based system and its ability to support individuals based on their needs, regardless of diagnosis, including individuals with significant support needs and those who are returning to the community from institutional stays. Strategies maximize opportunities available through the Affordable Care Act10 that both increase revenue to the State and begin to address the fragmentation that currently exists in Connecticut's HCBS systems.

Initially, strategies relate to ensuring that people have access to information through action steps including implementation of a global communication plan. While the global communication plan will include multiple outreach methods, the new LTSS website will be the primary communication tool. The State plans to build an interactive website using the existing LTSS website as a foundation.

Not only do consumers and caregivers need information, but they need streamlined means of accessing supports. Further, the State needs a means of comparing utilization and expenditures across populations. Standardizing assessment is the key first strategy in creating parity across age and disability and assuring fiscal controls supporting comparative analysis across the various LTSS settings, including nursing homes. Standardizing assessment will result in standard levels of need which will be linked to standard budget allocations. Needs assessment data will be linked to the Medicaid Management Information System so that level of need data, individual budgets and expenses across LTSS can be analyzed easily with common metrics Development and implementation of a common core needs assessment is an important SFY 2013 tactic which addresses the need for standardization.

With a common core needs assessment and stronger financial controls in place, the State can begin to explore some of the fragmentation that exists within the community LTSS. The strategic plan explores implementation of the Community First Choice option. This option has the potential of not only

[10] Patient Protection and **Affordable Care Act**, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

serving cross disability and age populations but also increasing revenue through a 6% enhanced federal match. The Community First Choice option would add personal care assistance to the Medicaid State plan, serving persons currently served under waivers at nursing home level of care, and offering coverage to those currently on waiting lists. Further analysis is needed to determine whether these additional costs would be offset by the additional revenue. Throughout the three years of the plan, other options to address fragmentation in the system will also be explored such as the implementation of a 1915(i) state plan amendment to cover the service component in supportive housing and qualifying rest homes. Through Section 1915(i) of the Social Security Act, states are permitted to offer HCBS to persons not yet at NF level of care through a Medicaid state plan amendment. Examples of supportive housing services include supported employment, psycho-social rehabilitation and clinical services. Before the State can move forward with the Community First Choice option or the 1915(i) option, the State will need to model the benefit design and eligibility criteria and conduct an impact analysis reflecting costs associated with projected increases in demand and determine the extent to which these costs are offset by projected increases in revenue. Finally, the State will evaluate the feasibility of implementing a consolidated HCBS waiver for older adults and individuals with disabilities.

The strategic plan addresses several key service gaps in HCBS waiver services, most notably a redesign of respite for informal caregivers. The economic value of family care giving was estimated at $450 billion in 2009 based on 42.1 million caregivers age 18 or older providing an average of 18.4 hours of care per week to care recipients age 18 or older, at an average value of $11.16 per hour. 11The Department plans to convene a focus group of caregivers to discuss and make recommendations on the redesign in the first year of this plan. Current considerations include the design of a flexible individual budget that would provide the caregiver with respite options – from a short NF stay for the participant to short-term in-home support. Redesign of this benefit not only supports family caregivers desperately trying to keep their family member at home, but also is a cost effective intervention since it reduces reliance on the formal system. Often family members 'burn-out' and turn to institutional care since they see no other viable option. This strategic plan aims for Connecticut to lead the nation in supporting family values by providing the support families need while caring for a family member at home. UCONN will evaluate the respite options as part of the MFP demonstration and produce a report in year 3 for the purpose of incorporating improved respite into HCBS waivers.

[11] Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving, Feinberg, L, Reinhard, S, Houser, A, and Choula, R, AARP Public Policy Institute

Another major focus of the HCBS strategy is the philosophical shift from a LTSS system primarily medical in orientation to one that is person-centered. Within the context of this strategy, policies and practices of the system will be analyzed to assure that they reflect a person-centered service delivery and decision making model. The discussion of risk and liability is central to this shift. Year one of the strategy begins with implementation of new policies regarding the administration of medication in support of nurses delegating to certified home health aides.

Goal: To improve effectiveness and efficiency of Connecticut's HCBS system

Metric: 58% of Medicaid LTSS participants are receiving HCBS

SFY 2013 – 2015 Strategies and Tactics

Strategy: Connect people to LTSS information and services

- Create global communication plan integrated with workforce communication plan
- Develop tools, including a LTSS website that builds upon existing sources, to educate public regarding HCBS, employment, spousal assessment, etc.

Metrics:

1. **Increase in the number of 'hits' on the website;**
2. **Increase in the number of physician offices and other target locations, such as libraries and hospitals, with information regarding community LTSS;**
3. **Increase in the number of callers to Connecticut Aging & Disability Resource Centers (ADRCs) who identify the place they heard about services as the LTSS website or other education initiative;**
4. **The percentage increase in the targeted population aware of community LTSS options.**

Strategy: Create parity across age and disability resources based on functional support needs rather than diagnosis

- Create and implement a common core needs assessment and budget allocation methodology for standardization across LTSS.
- Explore methods to link needs assessment data to MMIS so that level of need data, individual budgets and expenses across LTSS can be analyzed easily with common metrics;

- Review consolidation of existing personal care assistance services across all waivers into a Community First Choice State Plan amendment, reducing fragmentation across populations and qualifying for an additional 6% FMAP;
  - Initiate the common core assessment tool and methodology with the Community First Choice cross disability population.
- Streamline eligibility, payment, service availability, rates, cost caps, age requirements or gaps.
- Consider design of a consolidated waiver for adult individuals who are aging or adults with physical disabilities and analyze cost implications
- Train staff on all systemic changes.

Metrics:

1. **Increase in the number of HCBS serving cross disability populations;**
2. **Decrease in the variance in funding levels and services provided across LTSS for people at the same level of need;**
3. **Increase in self-reports of access to services and met needs;**
4. **Progress on stated goals of the Integrated Care Demonstration for Medicare and Medicaid Eligibles (MME).**

Strategy: Close service gaps and improve existing services or identify new services to better serve the needs of all populations.

- Coordinate with MME Demonstration to assure alignment and synergy;
- Undertake comprehensive review of all closed MFP cases to understand reasons for closure and what solutions can be implemented to reduce the frequency of case closure;
- Produce report on reasons for MFP case closures to define gaps in HCBS services or process;
- Provide additional flexibility and cost effective services by integrating adult family home model, independent support broker, alcohol and substance abuse, and peer support services;
- Build new service provider networks to assure capacity;
- Simplify home modification process;
- Integrate employment into MFP and HCBS;
- Explore a 1915(i) amendment to fund supports for Supportive Housing and for qualifying rest homes;
- Explore current NF level of care within the context of LTSS and make recommendations to improve access to services;
- Implement respite service reform in support of family caregivers.

Metrics:

1. **Decrease in the percentage of closed MFP cases.**
2. **Increase in number of care-givers reporting satisfaction with respite services;**
3. **Increase in the number of participants using adult family homes, alcohol and substance abuse treatment and peer support**

Strategy: Create mechanisms to ensure quality in the care provided through HCBS

- Establish a quality improvement committee to ensure sound discovery and remediation techniques and to identify and fix issues quickly within the community;
- Establish a seamless quality improvement strategy across waivers, MFP and State Plan HCBS including adult family homes;
- Develop strategies to assure conflict-free case management;
- Increase ability of long-term care ombudsman to review home care issues.

Metrics:

1. **Increased number of case management agencies with no conflicts;**
2. **Decreased number of critical incidents;**
3. **Decreased number of complaints to long-term care ombudsman.**

Strategy: Build, improve quality of provider networks aligned with the principles of person centered planning

- Educate providers regarding informed risk;
- Cross train HCBS waiver providers;
- Analyze policies and regulations and recommend change based on principles of person-centered decision making;
  - Implement systemic changes to advance nurse delegation of medication;
  - Develop nurse leadership institute for the sharing of best practices in person-centered care and nurse delegation;
  - Provide training to certify staff in medication administration;
  - Explore legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs who are willing to undertake some informed risk for needs that extend beyond the care traditionally provided by agencies;
  - Explore legislation to enable home health agency-affiliated nurses to train PCAs without incurring liability related to ongoing supervision;

- Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances;
- Ensure quality of care through independent evaluation of providers.

Metrics:

1. **Increase in the number of people/agencies utilizing risk agreements;**
2. **Increase in the acuity level of community LTSS participants;**
3. **Increase in the number of trained and certified home health aides.**
4. **Increase in the number of certified home health aides administering medication;**
5. **Increase in the number of electronic devices dispensing medication.**

Workforce

Overview

As the State begins to operationalize its efforts to right-size its LTSS services between NFs and HCBS, there are many important issues to consider. Chief among them is assessing the workforce capacity as a result of rebalancing the delivery system. As demand for HCBS increases, the demand for paid and unpaid direct care workers will also increase. Between 2006 and 2030, the population over the age of 65 is expected to increase by 64%, while the working-age population is expected to decrease by 2%. This gap will decrease the supply of informal caregivers as well as the pool of direct care workers. Understanding and leveraging the informal caregiver supply while making the direct care field an attractive option for job seekers is a key component of LTSS right-sizing. As Connecticut aggressively pursues Medicaid rebalancing goals, the need for focused efforts to recruit, train, retain and support paid and unpaid caregivers is essential. Without a focused, coordinated approach, lack of caregivers will stall rebalancing efforts and Connecticut will fail to meet its goals. The State will begin its strategic approach by developing a comprehensive workforce development communication plan.

Goal: To build capacity in the community workforce sufficient to sustain rebalancing goals

Metric: Increase in number of direct care workers as reported by Department of Labor and fiscal intermediaries

SFY 2013 – 2015 Strategies and Tactics

Strategy: Continuously promote workforce initiatives that are proven to support consumer choice, self direction and quality while enhancing recruitment, retention, productivity and training of the paid and unpaid direct care workforce

- Create statewide inventory of the existing workforce needs, future demand and national and local initiatives that show promise and scalability;
- Track national policy and practice trends to ensure Connecticut's workforce development strategy is synergistic with responsible national goals;
- Create statewide inventory of Connecticut's workforce activities embedded in state-funded and Medicaid waiver programs.
- Promote model re-training programs that would allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community;
- Promote employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal care giving training models;
- Seek to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor. The development and use of technology is proven to increase productivity of the direct care worker as well as increase the independence of the consumer;
- Identify similarities between the paid workforce and unpaid caregivers and coordinate development initiatives to leverage resources and avoid overlap;
- Inform the work of the Personal Care Attendant Quality Home Care Workforce Council.

Metrics:

1. **Increase in the percentage of institutionally based staff completing community LTSS training, including person-centered planning;**
2. **Decrease in turnover of paid direct-care staff;**
3. **Decrease in number of unpaid caregivers reporting burden.**

Strategy: Increase synergy with Connecticut's workforce system and support their efforts to create a pipeline of direct care workers with opportunities for career ladders to health and human/social services professions

- Orient workforce leaders to the demand and the guiding principles for long-term care in Connecticut;

- Partner with state and local workforce systems such as workforce investment boards (WIB's) and Connect-Ability to align recruitment and training efforts towards the demand for community-based direct care workers.;
- Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to health care reform of the need and conditions of the direct care workforce and unpaid caregivers;
- Create and endorse a common set of core competencies with emphasis on communication, relational skills, and understanding risk that helps paid and unpaid workers deliver person-centered care. *These core competencies should enhance consumer self-direction and should be careful not to infringe on the right of the consumer to train and direct their care;*
- Identify additional competencies and advanced competencies needed to create clearer career pathways in health and human/social service professions;
- Collaborate with the community college system to design direct-service curricula using a foundation of person-centered care;
- Foster training or re-training programs at multiple venues including community colleges, employers, and private/public partnerships.
- Increase and streamline ability to hire family members as paid caregivers.

Metrics:

1. **Increase in the number of direct care workers achieving competency;**
2. **Increase in the number of persons graduating from training programs;**
3. **Increase in family members hired as paid caregivers.**

Strategy: Create equity across state systems

- Identify, analyze and catalog variations across state departmental practices, policies and regulations that affect the paid and unpaid direct care workers;
- Identify, analyze and catalog systemic similarities and differences among state agencies with regards to wages of direct care workers and make recommendations to produce more equity;
- Identify, analyze and catalog systemic similarities and differences among state agencies in the handling of workers' compensation and unemployment claims and make recommendations to produce more equity;

- Identify, analyze and catalog systemic similarities and differences among state agencies in their policies and procedures related to use of assistive technology in care planning and make recommendations to produce more equity.

Metrics:

1. **Increase in the number of publications;**
2. **Changes in state agency policies/procedures to carry out recommendations.**

Strategy: Raise awareness of the importance and value of the direct care worker and unpaid caregiver

- Create workforce communication plan;
- Increase connectivity, networking, and training among both paid and unpaid caregivers;
- Increase awareness of support programs available to unpaid caregivers;
- Research and identify national best practice models that address wages and benefits;
- Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers.

Metrics:

1. **Increase in the number of website inquiries regarding workforce;**
2. **Increase in the number of job seekers accessing new LTSS website;**
3. **Increase in the percentage of job seekers obtaining employment through new LTSS website;**
4. **Increase in the number of companies with unpaid caregiver support programs and number of employees using them.**

Housing and transportation

Overview

Housing

Provision of affordable, safe and accessible housing plays a critical role as Connecticut assists Medicaid consumers to either remain in or return to the community. Appropriate housing opportunities for HCBS consumers can vary greatly and are frequently the primary barrier for LTSS consumers to receive HCBS. In order for the State to accomplish its LTSS right-sizing goals, it will be necessary to have an adequate supply of housing so the established rebalancing targets may be accomplished.

Housing options include a person's own home (owned, leased, or shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes (rest homes). Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community. Key to the State's strategy is the establishment of a Medicaid housing plus supports specialist to assure coordination between the Department of Housing and Medicaid LTSS.

Transportation
Transportation becomes central in providing Medicaid consumers access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers in order to provide the care needed for consumers to successfully remain in or return to the community. Frequently acknowledged as one of the greater unmet needs in communities, it is frequently not accessible or affordable.

Goal: To increase availability of accessible housing and transportation

Metrics:

1. **Increase in the number of subsidized units in the State;**
2. **Increase in number of towns with affordable, flexible transportation options.**

SFY 2013 – 2015 Strategies and Tactics

Strategy: Foster partnership and cross-agency collaboration between agencies focused on housing and transportation.

- Establish a strategic partnership between DSS, the new Department of Housing, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD), Department of Transportation (DOT) and the U.S. Housing and Urban Development (HUD);
- Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to development of housing plus support models;
- Establish a housing and transportation unit to specifically build relationships with partners in order to increase available units, increase resources for housing and transportation, and increase coordination of services and supports with housing;

- Leverage new relationships to access additional housing vouchers via grants and identify project-based housing units that are currently vacant for housing of transitional clients;
- Foster collaboration with Connect-Ability transportation initiatives.

Metrics:

1. **Increased number of housing committees with Medicaid representation;**
2. **Increased number of grants submitted to access housing funds;**
3. **Increased number of Medicaid staff assigned to housing and/or transportation.**

Strategy: Provide natural supports and caregivers with transportation and housing assistance

- Establish coalitions for community transportation to assist with ride shares;
- Explore the use of Zip car-like rentals service, school buses or NEMT transportation brokers, negotiated transportation rate and network available as a service under HCBS ;
- Develop more opportunities to utilize HUD's Section 202 housing program to assist in housing shortage;
- Analyze additional means to establish how home sharing could assist family and caregivers with respite.

Metrics:

1. **Increase in the number of 1915(c) waivers with non-medical transportation as a service option;**
2. **Increase in numbers of community transportation coalitions and alternative transportation options (zip cars, school buses, IT-N I);**
3. **Increase in number of Section 202 subsidized units.**

Strategy: Improve financing dollars for housing

- Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes;
- Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes;
- Establish new bonding dollars for affordable housing and, to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g.,

more home-like environments, more common space, designs for more space and environmental efficiencies).

Metrics:

1. **Increase in bond funding;**
2. **Increase in tax credits.**

Hospital and Nursing Home Discharges

Overview

Hospital discharge planning activities often drive patients to NFs in order to provide a safe discharge environment and act as an effective mechanism in transitioning consumers along the continuum of care to ensure that they receive the appropriate follow-up care and services they require. For Medicaid participants discharged from a hospital to a nursing home, the risk of long-term institutionalization is significant. Data shows that 65% of all Medicaid participants who enter NFs are still there after six months.[12] Thus, for vulnerable populations, entry into a NF can often lead to permanent institutionalization and loss of community ties and individual freedom of choice. Additionally, health services research indicates NFs could provide viable alternatives to acute inpatient admissions/re-admissions, effectively bypassing emergency departments (EDs) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can help to ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into the community.

Barriers that impact discharges from both nursing facilities and hospitals are addressed in this strategic plan. The primary barriers include lack of streamlined access to community supports, lack of standardized process for transitions between care settings, and lack of an expedited eligibility process. Key strategies in this plan focus on the establishment of a single point of entry that will result in quick linkages to community LTSS and transitional services and supports under MFP.

Goal: 1) Decrease hospital discharges to nursing facilities among those requiring care after discharge

2) Transition 5,200 people from nursing homes to the community by 2016

[12] Connecticut Commission on Aging Strategy Paper, December 2010, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fcoa%2FPDFs%2FFact%2520Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nqhsWUNuxCZBopnlQ, last accessed December 9, 2011.

Metrics:

1. **884 persons transitioned from nursing homes under MFP per year;**
2. **52% of persons discharged to community from hospitals.**

2013 – 2015 Strategies and Tactics

Strategy: Convene a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health and behavioral health issues.

- Develop Single Point of Entry and web-based resource for discharge planners;
- Develop strategies to promote electronic health records in LTSS settings (NF and HCBS);
- Coordinate activities with other ACA initiatives such as the MME Demonstration
- Build greater synergies between the various State, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings.

Metrics:

1. **Increased number of target populations (providers, consumers) satisfied with single entry point;**
2. **Increased number of people satisfied with town meetings;**
3. **Increased number of town meetings;**
4. **Increased number of consumers who use the single point of entry to (a) submit a prescreen, and (b) link to services.**

Strategy: Develop and implement standards in Transition of Care in coordination with other health care initiatives

- Improve collaboration to develop more definitive "handoffs" between hospitals, community resources, and other services and settings;
- Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses various State initiatives currently underway such as the Integrated Care Demonstration for dual eligibles;

- Collaborate with state Community-Based Care Transition Program (CCTP) efforts.

Metrics:

1. **Decrease in variance between state transition processes;**
2. **Reduction in 30 day hospital readmissions among Medicaid LTSS users.**

Strategy: Improve process for LTSS eligibility.

- Participate in DSS internal process review to streamline LTSS eligibility ;
- Research other state practices and report recommendations on 5 year look-back options, exploring the underwriting risk of an expedited look-back process as compared to the cost of the existing process;
- Consider piloting new process for expedited look-back with MFP unit and select regional units and produce cost-benefit analysis to inform broader systemic change;
- Work to create and implement streamlined process for 5 year look-back statewide based on recommendations from above;
- Provide staff training;
- Provide incentives to local service providers (ADRCs, senior centers, municipal agents) to submit complete and accurate Medicaid applications.

Metrics:

1. **Decrease in length of time from initial contact with entry point to services in the community;**
2. **Increase in number of incentive payments to local service providers.**

Strategy: Provide MFP transitional and community services and supports to qualified persons who are institutionalized

- Partner with local organizations to provide transitional services to persons who are institutionalized;
- Determine core competencies and educate transition coordinators;
- Implement performance outcome payments;
- Continually improve housing plus supports model.

Metrics:

1. **Decreased length of time in transition;**

2. **Decreased rate of critical incidents;**
3. **Increased number of performance outcome payments.**

Nursing Facility Diversification and Modernization

Overview

The current State LTSS institutional landscape includes 235 NFs with a total of 26,467 beds and an average occupancy rate of 90.8%. The State ranks number three in the country for the number of facility residents per 100 state residents over age 65, at 5.8 compared to the national average of 3.8. The state also has ranked high in the proportion of low-acuity residents that live in NFs. According to data from the CMS *2008 Online Survey, Certification and Reporting* database, the average activities of daily living (ADL) score of a Connecticut NF resident was 3.7 while the national average was 4.0. Four states tied with Connecticut and only two states had a lower acuity score, demonstrating Connecticut's opportunity to transition or maintain more individuals in community settings.

As barriers that prevent Medicaid participants from having a choice to receive services in the community are diminished, demand for the current model of institutional care is projected to decrease. The State plans to use town level data maps referenced in Section 2 to identify high need areas of the state and to guide decision making. Criteria defining high need areas will include, but not be limited to, current nursing home census compared to current and projected demand for institutional care at a local level and current and projected demand for community LTSS compared to supply. Competitive grant funds will be available to nursing homes who work in partnership with their communities. The State acknowledges that the vision of local LTSS compendiums includes new models of institutional care. These institutional settings will reflect a stronger culture of person-centered care than is currently the norm in Connecticut and be more 'home-like' in orientation than many of the current models. While different nursing home models of care are an important consideration, the strategic priority for this 3 year plan is the development of community LTSS. During the first phase of this strategic plan, funds will be prioritized for high need areas and for those nursing homes who are interested in diversifying for the purpose of providing community LTSS.

Goal: To adjust supply of institutional beds and community services and supports based on demand projections

Metric:

1. **Increase in satisfaction of town members with local LTSS**

SFY 2013 – 2015 Strategies and Tactics

Strategy: Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community

- Review the impact of expanding Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.);
- Explore transitional training programs within NFs (including possible transitional units), including training and support for caregivers;
- Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs);
- Explore rates for transitional services;
- Redefine the Certificate of Need (CON) process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports; transitional services;
- Coordinate with other integrated care and home health initiatives.

Metrics:

1. **Decrease in average length of stay at facility;**
2. **Decrease in length of transition process;**
3. **Increase in percent of persons who can self-administer medication upon discharge;**
4. **Decrease in critical incidents during first 30 days post discharge;**
5. **Increase in employment rate within 6 months post discharge.**
6. **Alignment of the number of LTSS Medicaid NF beds with demand.**

Strategy: Transform NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity

- Reissue business plans and financial projections, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.);
- Support nursing homes working in collaboration with community stakeholders to build a town-based LTSS compendium consistent with the State's strategic plan;
- Explore NF as part of the town's emergency back-up and expanded respite system;
- Develop capacity to provide HCBS through NFs, including but not limited to therapies, home health, personal care, home-delivered meals, hospice

(facility and home), respite, memory impairment, transportation, concierge, adult day, assisted living, etc.;

- Support transformation of NFs into community housing;
- Coordinate with HUD to explore flexibility with existing NF financing;
- Develop community space at NFs;
- Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services;
- Promote person-centered care in nursing homes.
- Promote increased quality of care in nursing homes.

Metrics:

1. **Increase in number of nursing homes offering community LTSS;**
2. **Decrease in number of nursing homes with public health violations.**
3. **Decrease in the number of nursing home Medicaid beds statewide.**

4

Conclusions

The strategies identified within this plan for each of the key system elements represent important steps toward building a strong system of LTSS. Collectively, they will result in a redesigned service system that will afford individuals, even those with significant support needs, maximum choice and control over the type and location of their services. The State stands ready to make the very important efforts necessary to reconfigure the infrastructure as well as needed improvements to services and processes used within that framework.

Throughout the implementation of the strategic plan, Connecticut will continue to consider how the data, maps, and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information in conjunction with the experience of providers and local communities will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but, with regular evaluation, they should provide an appropriate context for determining next steps in the process. Through the continued level of engagement and commitment of the State and the stakeholders, the goals of the initiative are achievable.

Appendix A

Home and Community-Based Service Strategies and Tactics

SFY 2013 - 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Connect people to LTSS information and services	• Create global communication plan integrated with workforce communication plan		• Continue communication plan • Develop tools to educate public regarding HCBS, employment, spousal assessment, etc.	Web budget/WF budget	• Continue communication plan	Web budget/WF budget
Create parity across age and disability resources based on functional support needs rather than diagnosis –	• Analyze needs assessment and budget allocation methodology with respect to creating a common core for standardization across LTSS • Streamline, eligibility, payment, service availability, cost caps, age requirements or gaps • Analyze impact of consolidating existing personal assistance services into a Community First Choice State Plan amendment • Study the impact of a consolidated waiver for adult individuals who are aging or adults with physical disabilities and analyze cost implications	$300,000 MFP TA	• Select a common core tool and methodology and develop for use in Connecticut's LTSS · Assess feasibility of incorporating needs assessment tool with EMS, MSIS or other common platforms • Conduct impact analysis of Community First Choice option and if indicators support implementation: — Develop State Plan amendment adding Community First Choice Option — Implement Community First Choice Option utilizing standard common core assessment tool for all populations • Provide tools and training on common core assessment tool	$300,000 $1,000,000 Revenue projection $50,000	• If applicable, modify common core assessment tool across all LTSS and budget methodology based on experience with Community First Choice implementation • Provide training on new common core tool • Continue integration on to common platform	$25,000 $1,000,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Close service gaps and improve existing services or identify new services to better serve the needs of all populations	• Undertake comprehensive review of all closed MFP cases to understand reasons for closure and what solutions can be implemented to reduce the frequency of case closure • Design and implement adult family home model and independent support broker – design/fund outreach strategy to build provider networks • Simplify home modification process • Integrate employment into MFP and HCBS	$100,000 $125,000	• Continue comprehensive review in partnership with UConn; use SFY 2013 report to inform waiver and State Plan changes • Conduct impact analysis of a 1915(i) amendment to fund supports for Supportive Housing and for qualifying rest homes • Analyze and report on raising NF levels of care (eliminating ICF) and replacing with 1915(i) • Design, implement, and evaluate peer support model as MFP Demonstration • Design, implement and evaluate improved respite and other supports for informal caregivers under MFP • Implement outreach for adult family homes and independent support broker to build provider networks • Design, implement and evaluate alcohol substance abuse demonstration under MFP	$100,000 Revenue Rev $100,000 $250,000 $25,000 $250,000	• Continue to evaluate UConn reports and integrate findings into LTSS system • If applicable, evaluate 1915(i) implementation and modify if necessary • Modify LOC based on report • Expand peer support to entire system based on evaluation • Continue to demonstrate respite and other supports to informal caregivers and publish findings • Evaluate and modify outreach developing adult family homes – continue to build network • Design, implement and evaluate alcohol substance abuse demonstration under MFP	$100,000 $100,000 $250,000 $25,000 $250,000
Create mechanisms to ensure quality	• Establish quality improvement	Align	• Establish a seamless quality	•	• Continue quality improvement	•

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
in the care provided through HCBS	committee to ensure sound discovery and remediation techniques and to identify and fix issues quickly within the community.	existing resources to assign FTE to QA	improvement strategy across waivers, MFP and State Plan HCBS including adult family homes • Develop strategies to assure conflict-free case management		discovery and remediation • Increase ability of LTC Ombudsman to review homecare • Promote conflict-free case management	
Build, improve quality of provider networks aligned with the principles of person centered planning	• Continue education to providers regarding informed risk • Cross train HCBS waiver providers • Improve medication administration regulation and training · Develop nurse leadership institute for the sharing of best practices in person-centered care and nurse delegation · Explore grants to HH for participation in Nurse Delegation Evaluation · Provide training to certify staff in med admin · Evaluate nurse delegation model • Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances	$25,000 $5,000 $20,000 50,000 $40,000 $50,000	• Continue education to providers regarding informed risk • Continue cross training waiver providers • Continue education and outreach to home health agencies and support of nurse leadership institute • Explore grants to HH for participation in Nurse Delegation Evaluation · Expand network of medication certification trainers and certify additional staff · Continue evaluation of nurse delegation • Explore legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs and who seek to undertake some informed risk beyond the care typically	$25,000 $10,000 $15,000 $50,000 $80,000 $100,000	• Continue education to providers regarding informed risk • Continue cross training waiver providers • Continue education and outreach to home health agencies and support of nurse leadership institute; • Explore grants to HH for participation in Nurse Delegation Evaluation · Expand network of medication certification trainers and certify additional staff · Continue evaluation of nurse delegation	$25,000 $10,000 $15,000 $50,000 $80,000 $100,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
			provided by the agency • Explore legislation to support home health agency nurses training PCAs • Ensure quality of care through independent evaluation of providers			

Workforce Strategies and Tactics

SFY 2014 and 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Continuously promote workforce initiatives that are proven to support consumer choice, self direction and quality while enhancing recruitment, retention, productivity and training of the paid and unpaid direct care workforce.	• Create statewide inventory of the existing workforce needs, current activities, future demand and national and local initiatives that show promise and scalability.	MFP TA	• Prioritize and promote promising practices across the state	Included in website development budget	• Prioritize and promote promising practices across the state	Included in website development budget
	• Track national policy and practice trends to ensure Connecticut's workforce development strategy is synergistic with responsible national goals.		• Create Connecticut report card regarding direct care workforce strategies		• Continue Connecticut report card regarding direct care workforce strategies	
	• Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to	$175,000	• Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to	$175,000	• Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained	$175,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	provide services and supports in the community. • Seek to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor. *The development and use of technology is proven to increase productivity of the direct care worker as well as increase the independence of the consumer.* • Identify similarities between the paid workforce and unpaid caregivers and coordinate development initiatives to leverage resources and avoid overlap. • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council		provide services and supports in the community. • Continue to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor • Continue to coordinate development of initiatives related to paid and unpaid caregivers • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council • Identify employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal caregiving training models.		to provide services and supports in the community. • Continue to include research and development of technology in new jobs creation and various business initiatives promoted by the Governor • Continue to coordinate development of initiatives related to paid and unpaid caregivers • Inform the work of the Personal Care Attendant Quality Home Care Workforce Council • Prioritize and promote identified employer/employee training models in a variety of community-based workplace settings, including self-directed employment arrangements and informal caregiving training models.	

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Increase synergy with Connecticut's workforce system and support their efforts to create a pipeline of direct care workers with opportunities for career ladders to health and human/social services professions	• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut. • Partner with state and local workforce systems such as workforce investment boards (WIB's) and Connect-Ability to align recruitment and training efforts towards the demand for community-based direct care workers. • Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to health care reform of the need and conditions of the direct care workforce and unpaid caregivers. • Create and endorse a common set of core competencies with emphasis on communication, relational skills, and understanding risk that helps paid and unpaid workers deliver person-centered care. *These core competencies should enhance consumer self-direction and should be careful not to infringe on the right of the consumer to train and direct their care.* • Identify additional competencies and advanced competencies		• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut. • Identify priority recruitment and training goals and incorporate into workforce communication plan • Assure MFP representation on key workforce councils and committees • Integrate competencies within LTSS system		• Orient workforce leaders to the demand and the guiding principles for LTSS in Connecticut • Identify priority recruitment and training goals and incorporate into workforce communication plan • Assure MFP representation on key workforce councils and committees • Strengthen QA systems to assure compliance with competencies	Included in website development budget

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	needed to create clearer career pathways in health and human/social service professions • Collaborate with the community college system to design direct-service curricula using a foundation of person-centered care. • Foster training or re-training programs at multiple venues including community colleges, employers, and private/public partnerships.	$25,000	• Assure curricula for direct workforce is consistent with person-centered planning; • Prioritize and promote training or re-training needs and support development at community colleges • Increase and streamline ability to hire family members as paid caregivers		• Prioritize and promote training or re-training needs and support development at community colleges	
Create equity across state systems.	• Identify, analyze and catalog variations across state departmental practices, policies and regulations that affect paid and unpaid direct care workers. • Identify, analyze and catalog systemic similarities and differences among state agencies with regards to wages of direct	MFP TA	· Publish prioritized report re: identification, analysis and cataloging of SFY 2013 tactics including recommendations for change in procedure, policy or practice in SFY 2015; · Identify key leverage points for change based on the report		• Address top leverage point from SFY 2014 report and advance implementation	TBD

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	care workers, make recommendations to produce more equity. • Identify, analyze and catalog systemic similarities and differences among state agencies in the handling of workers' compensation and unemployment claims, make recommendations to produce more equity. • Identify, analyze and catalog systemic similarities and differences among state agencies in their policies and procedures related to use of assistive technology in care planning, make recommendations to produce more equity.					
Raise awareness of the importance and value of the direct care worker and unpaid caregiver.	• Create workforce communication plan • Increase connectivity, networking, and training among both paid and unpaid caregivers. • Increase awareness of support programs available to unpaid caregivers.	$350,000	• Continue workforce communication plan phase 2 • Develop a local repository or clearinghouse that provides opportunities for linkages at a local level and allows consumers to identify providers of services and supports with website • Research and identify national best practice models that address wages and benefits. • Promote flexibility in workplace	$150,000	• Continue workforce communication plan phase 3; • Publish report on national best practice models that address wages and benefits; • Promote flexibility in workplace	$150,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
			employment policies and practices to accommodate the circumstances of unpaid family caregivers		employment policies and practices to accommodate unpaid family caregivers	

Housing and Transportation Strategies and Tactics
SFY 2013- 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Foster partnership and cross-agency collaboration between agencies focused on housing and transportation	• Establish a strategic partnership between DSS, the new Department of Housing, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD), Department of Transportation (DOT) and the U.S. Housing and Urban Development (HUD) • Establish a housing and transportation unit to specifically build relationships with partners in order to increase available units and resources for housing and transportation • Leverage new relationships to access additional housing vouchers via grants and identify project-based housing units that are currently vacant for housing of transitional clients	FTE MFP Staff	• Foster collaboration with DOT to establish different guidelines for caregivers providing transportation with a goal of increasing pay • Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to housing plus supports	•	• Inform and assist existing statutorily and gubernatorial mandated working groups that are committed to housing plus supports	•
Provide natural supports and caregivers with transportation and housing assistance	• Analyze additional means to establish how home sharing could assist family and caregivers with respite	(Analysis taking place under Adult	• Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes	$2,000,000	• Provide competitive low cost loans to finance adult family homes or to convert rest homes to adult family homes	$2,000,000

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
		Family Home Model under HCBS strategy)	• Establish coalitions for community transportation to assist with ride shares • Explore the use of Zip car-like rental services, school buses or NEMT transportation brokers, transportation rate and network available as a service under HCBS · Develop more opportunities to utilize the Section 202 housing program to reduce housing shortage			
Improve financing dollars for housing.	Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000	• Establish new bonding dollars for affordable housing and, to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g., more home-like environments, more common space, designs for more space and environmental efficiencies) • Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000	· Provide funding for accessibility modifications supporting both MFP and accessibility for adult family homes	$1,000,000

Hospital/ Nursing Home Discharge Strategies and Tactics

SFY 2013 - 2015

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Convene a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health and behavioral health issues.	• Devise and implement a global communication plan raising awareness of LTSS options	$125000	• Promote global communication	$250,000	• Promote global communication	$250,000
	• Communicate progress on rebalancing efforts through statewide event	$30,000	• Communicate progress on rebalancing efforts through statewide event	$30,000	• Communicate progress on rebalancing efforts through statewide event	$30,000
	• Develop Single Point of Entry and web-based resource for discharge planners	$275,000	• Continue phase 2 of website	$500,000	• Continue phase 3 of website	$250,000
	• Develop strategies to promote electronic health records in LTSS settings (NF and HCBS).					
	• Build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings		• Continue to build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings	$25,000	• Continue to build greater synergies between the various state, regional and city organizations that all have a role in promoting LTSS and HCBS options by hosting town meetings	$25,000
Develop and implement standards in Transition of Care in coordination with other health care initiatives	• Improve collaboration to develop more definitive "handoffs" between hospitals, community resources, and other services and settings		• Design, develop and implement training for transitions of care	$25,000	•	•
	• Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses					

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	various State initiatives currently underway such as the Integrated Care Demonstration for dual eligibles					
Improve process for LTSS eligibility	• Inform DSS LEAN process • Create and participate in national task force • Research and report recommendations on 5 year look-back options • Explore underwriting risk of expedited look-back process compared to cost of existing process; • Work to create and implement a streamlined process for 5 year look-back statewide	•	• Continue SFY 2013 activities • Pilot new process for expedited look-back with MFP unit and select regional units and produce cost-benefit analysis to inform broader systemic change; • Provide staff training • Provide incentives to local service providers serving as single entry points to submit complete Medicaid applications	•	• Continue SFY 2014 activities	•
Provide transitional and community services and supports through MFP to persons who are institutionalized	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition coordinators; • Provide performance outcome payments; • Continually improve housing plus supports model • Increase capacity to transition persons under 65 by hiring 3 CCT social workers	$100,000 $195,336 $6,710,375	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition coordinators; • Provide performance outcome payments; • Continually improve housing plus supports model • Continue implementation of MFP Demonstration	$100,000 $6,478,747	• Partner with local organizations to provide transitional services to persons who are institutionalized; • Determine core competencies and educate transition coordinators; • Provide performance outcome payments; • Continually improve housing plus supports model • Continue implementation of MFP	$100,000 $6,518,715

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	• Continue implementation of MFP Demonstration				Demonstration	

Nursing Facility Diversification and Modernization Strategies and Tactics

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community	• Review the impact of expanding Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.) • Create additional transitional training programs within NFs (including possible transitional units), including training and support for caregivers, alcohol and substance abuse, independent living skills and pre employment skills • Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs) • Develop rates for transitional services as pre-discharge community service • Establish authorization process for services and individual plan requirements • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it		· Review SFY 2013 tactics and revise as necessary; · Modify receivership legislation to integrate MFP informed choice process;		Review SFY 2014 tactics and revise as necessary	

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	supports transitional services • Coordinate with other integrated care and home health initiatives					
Transform NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity	• Reissue business plans and financial projections, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.) • Develop capacity to provide community-based services through NFs, including but not limited to therapies, home health, personal care, home-delivered meals, hospice (facility and home), respite, memory impairment, transportation, concierge, adult day, assisted living, etc. • Development of community space at NFs • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services • Develop RFP for nursing facilities interested in diversifying to provide community supports as identified in town level data maps	RFP $13,000,000	• Review implementation of SFY 2013 tactics, revise as necessary; • Develop RFP for funding of additional proposals from nursing homes; • Review statutes and recommend changes aligned with advancing the strategic plan; • Explore close-out rate for nursing homes	RFP $15,760,000 ($10M in bonds)	• Review implementation of SFY 14 tactics, revise as necessary; • Review statutes and recommend changes aligned with advancing the strategic plan	RFP $15,760,000 ($10M in bonds)

Strategy	SFY 13 Tactic	SFY 13 Budget	SFY 14 Tactic	SFY 14 Budget	SFY 15 Tactic	SFY 15 Budget
	• Develop prioritization for awards based on NF quality, unneeded institutional beds and need for additional community services and supports at a town level • Analyze local supply and demand trends and produce 6 month updates	$50,000	• Analyze local supply and demand trends and produce 6 month updates	$100,000	• Analyze local supply and demand trends and produce 6 month updates	$100,000

Appendix B

Report from the Long-Term Care Right-Sizing Strategic Planning Retreat: Participant Strategies to Address Long-Term Care Rebalancing Efforts State of Connecticut April 16, 2012

MERCER

CONSULTING. OUTSOURCING. INVESTMENTS.

REPORT FROM THE LONG-TERM CARE RIGHT-SIZING STRATEGIC PLANNING RETREAT:

PARTICIPANT STRATEGIES TO ADDRESS LONG-TERM CARE REBALANCING EFFORTS

STATE OF CONNECTICUT

APRIL 16, 2012

MARSH & McLENNAN COMPANIES

CONTENTS

1

Introduction

The State of Connecticut (State) is committed to creating a more efficient and effective long-term support and service system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need long-term services and supports (LTSS) to choose whether they want to receive these services in a nursing facility (NF) or in a community setting. When asked whether or not an individual would prefer to receive services in a NF or in their home in the community, the vast majority of individuals indicated that they prefer to remain in their homes. The State also acknowledges that over the next several years the number of people who need LTSS will increase dramatically due to the aging population. In order to attain the vision of enhanced qualify of life and increased choice for individuals within their own communities, the concept of a town-based LTSS continuum was developed. Honoring the autonomy of the towns within Connecticut, the State supports a town-based approach to LTSS continuums that will provide choices apart from independent living in the community, ranging from various types of assisted living settings to care provided in a nursing facility; these options will support a seamless transition from hospital to short-term rehabilitation and back into the community. These continuums will be based on the preferences of the people they are designed to serve.

The trend toward receiving LTSS in the community, combined with the aging population, will cause a rapid growth of the need for community-based LTSS over the next ten to fifteen years. A change of this magnitude requires careful planning and collaboration between State, local and private entities. The Right-sizing Initiative was developed to accomplish this. Data from various sources will be incorporated into the State's utilization and cost projection model described in Section 2 of this report. Updated on a quarterly basis, this model will be used to project supply and demand for LTSS at a town level. More specifically, it will identify areas of the state where there is an excess of NF beds and areas where there may not be enough beds, and areas where transitional programs and additional community LTSS are needed. The model will extrapolate trends within towns at a sufficient level of detail so that supply and demand of specific services such as personal care attendants, transportation or housing will be readily identifiable. Based on the principle of choice, the model assumes that barriers preventing choice in where Medicaid recipients receive LTSS are removed. It will serve as an important tool guiding decisions regarding investments in LTSS moving forward.

According to the US Administration on Aging's Profile of Older Americans[1], the number of people age 65 and older is expected to grow to 19.3% of the population by 2030, marking a significant growth as a portion of the population nationally. This trend is evident in the Connecticut, where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025.[2] Notably, in the November 2011 report entitled *90+ in the United States: 2006-2008*[3], Connecticut ranked second among States with the highest percentage of the population Aged 90 and Over of Aged 65 and Over: 2006–2008. . The report also notes that research shows that age is positively associated with the presence of physical difficulty, and the oldest have the highest levels of physical and cognitive disability. By 2025, demand for LTSS is expected for more than 64,000 individuals in Connecticut – an increase of more than 24,000 individuals over current levels.[4]

The following graph displays the projected growth of the total demand for long-term care (LTC) services in Connecticut as well as the expected change in the mix between home- and community-based services (HCBS) and NF services. While the demand for LTC services is expected to grow to close to 64,000 users in 2025, the mix between HCBS and NF services is expected to move from the current HCBS/NF mix of 53%/47% to 83%/17% in 2025.[5] Changes in the HCBS/NF mix are largely attributed to interventions funded by the State's Money Follows the Person (MFP) rebalancing demonstration. Interventions are designed to eliminate barriers which prevent choice in where users receive their LTSS.

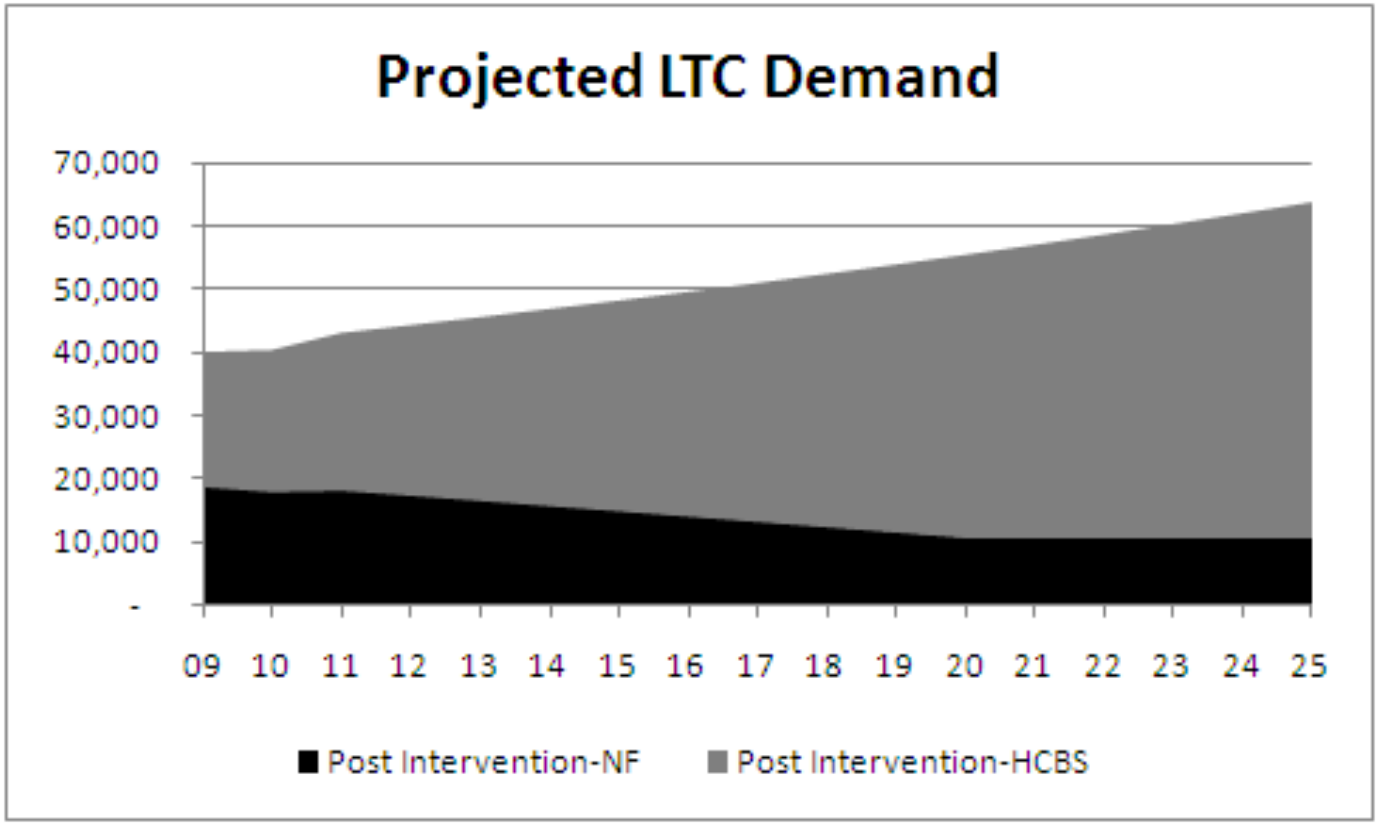
[1] US Administration on Aging. A Profile of Older Americans: 2010 (updated February 25, 2011).

[2] Connecticut Long Term Care Planning Committee, "Long Term Care Plan: A Report to the General Assembly", January 2010, page 42, table 5.

[3] Wan He and Mark N. Muenchrath, US Census Bureau, American Community Survey Reports, ACS-17, *90+ in the United States: 2006-2008*, US Government Printing Office, Washington, DC,2011.

[4] Jaramillo, Ernest ASA, MAAA, MBA; Medicaid Long Term Care Services and Supports Utilization and Cost Projection Model, State of Connecticut – Department of Social Services. November 30, 2011.

[5] Ibid.



To structure a service delivery system to meet the anticipated needs for LTSS and improve person-centered care systems for individuals with disabilities and aging individuals Connecticut has embarked on a LTC Right-sizing Initiative to identify system strengths and strategies to ensure the availability and service arrays preferred by and necessary to support the current and future users of LTC in the State. In partnership with individuals who are aging, individuals with disabilities, their families, community and institutional LTSS providers, advocates and other stakeholders, Connecticut seeks to align the supply of LTSS within the system with the anticipated demand for increased home- and community-based options. Connecticut recognizes that this effort has broad implications for individuals

receiving services, entities that provide those services and other critical stakeholders. To that end, Connecticut seeks to identify strategies that reflect both the strategic and the business considerations in these efforts.

Currently, Connecticut spends 65% of its LTSS dollars on institutional care for individuals who are aging and individuals with physical disabilities (excluding individuals with intellectual or developmental disabilities).[6] A 2011 analysis of adults age 31 and over using Medicaid LTC services shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and in 2008: Total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older.[7] Offering greater options for community-based services as an alternative to the continued reliance on institutional care will enable the State to be more cost effective and more responsive to the preferences of the individuals likely to need services.

The right-sizing initiative will draw upon the strengths of the existing system, ensuring that the institutional providers within the State continue to serve an essential role in the care continuum while also diversifying and bringing their significant expertise to bear in other areas of the service system. The initiative further relies on the expert input of a wide array of stakeholders to ensure that the rebalanced LTSS system embodies the structures, philosophies and options necessary to meet the needs and preferences of individuals served for the coming decades.

Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the LTC Right-sizing Strategic Planning Retreat, Connecticut has sought the input and expertise of those interested in building a sustainable LTSS system within the State. With an unprecedented level of partnership and collective work toward the common goals, the participants in these efforts have contributed heavily to this strategic planning retreat which will be considered by the State to establish a LTC right-sizing strategic plan and LTSS system designed to meet the unique needs of the State's future.

[6] Connecticut Long Term Care Planning Committee; Long Term Care Plan: A Report to the General Assembly; January 2010; p. 54, Table 15.

[7] *American Journal of Public Health*, September 2011, Vol. 101, No. 9; "Relations Among Home- and Community-Based Services Investment and Nursing Home Rates of Use for Working-Age and Older Adults: As State-Level Analysis", Nancy A. Miller, PhD.

Specifically, this planning retreat addressed key elements within the LTC system that require further re-engineering in order to meet the State's LTC right-sizing goals such as:

- Home and Community Based Services
- Workforce
- Housing and transportation
- Hospital transitions
- NF diversification and modernization
- MFP grants

While representing distinct features and challenges within the system, these elements are interrelated, and in some instances, interdependent – and all must be addressed to improve the LTSS system to ensure a strong and responsive person-centered care continuum and to establish State policies that maximize individuals' independence and control. Initiatives developed within a plan as a result of this retreat will be aligned with the State's vision for a LTC continuum as defined by the LTC Planning Committee and MFP rebalancing demonstration; the vision is guided by the principles of individual participant choice, dignity and autonomy. The vision and principles are also aligned with the Department of Social Services' (DSS') mission of being committed to promoting and supporting individuals' choice to reside in their own home and community.

Throughout the process the level of engagement, interest and collaboration of the planning retreat participants in providing their time, expertise and candid comments have helped to shape the participants' recommendations for LTC right-sizing strategy as it appears below. The State would like to recognize their efforts in support of advancing the right-sizing vision. The next steps are to convene a smaller group and use this report to create a strategic rebalancing plan by identifying strategic leverage points emerging from the recommendations. The plan implemented in coordination with individual towns and communities will include:

- Specific strategies and tactics
- Methods for measuring progress and baseline data
- Estimated costs
- Timelines for implementation
- Potential new funding streams and opportunity to coordinate with existing funding streams

2

Utilization and cost-projection model for Medicaid long-term services and supports

In order to assist in the development of the State's right-sizing strategy, a data model was developed to project the demand for LTSS at the State level. The purpose of this data model is to estimate the future demand for LTSS as well as the impact of changes in the mix of services between institutional and HCBS. As part of the model development, the State emphasized the necessity of ensuring the model illustrated the impact of honoring the choice of consumers.

The model construction is divided into two phases: First, a high-level model, which will be carefully monitored and updated by the State, focusing on a macro view of LTSS over the next 15 years, including information regarding the array of individuals presenting a need for LTSS. In this first phase the model will use readily-summarized data from the American Community Survey as well as the historical Medicaid NF and HCBS participant information from State fiscal year 2004 to the present from the State's Office of Policy and Management.

The model construction during the first phase was broken down into three steps:

- Projecting the overall demand for LTC services
- Examining the effect over time to the HCBS/NF mix if existing trends persist absent the impact of any new initiatives
- Factoring in the impact to the HCBS/NF mix if existing initiatives accelerate or new ones are introduced

The second phase of the project is to construct a more detailed model to assess and address strategies at the local level. It is important to examine the issue at the macro level prior to the development of the more detailed local view so that potential systemic infrastructure issues which may exist can be taken into account. The more detailed model, which will use actual State Medicaid data, is expected to be completed in early February 2012.

3

Strategies for right-sizing

The workgroup that participated in the LTC right-sizing retreat and developed these strategies was comprised of a cross-section of individual LTSS stakeholders. Specifically, representation on this group included family members, advocates, ombudsmen, State staff, providers (community and institutional), academics and others. The strategies identified by this team are vital in achieving success and in building an equitable, objective and seamless system. While the State recognizes that a robust set of strategies are necessary to realize the LTC right-sizing goals that have been established, given the fact that resources are limited, the approach taken must be pragmatic. **Thus, the final set of recommendations that will comprise the first phase of activity will be selected based on considerations relating to the timing, resources and funding necessary to complete each strategy.**

Home- and community-based service options

Overview

HCBS support individuals with disabilities or individuals who need assistance with activities of daily living (ADLs) to live in their own home, with family or in other community settings. A diverse set of community-based service options is critical to support individuals to live in the most integrated setting possible outside of institutional settings such as NFs. As Connecticut develops these systems of support for community-based alternatives and improves the quality of the services, the State must consider how to best inform individuals of service choices and make new options available.

The strategies outlined below represent key steps to improve the home- and community-based system and its ability to support individuals based on their needs, regardless of diagnosis, including individuals with significant support needs and those who are returning to the community from institutional stays.

Strategies

Strategy	Tactic	Metric
Create parity across age and disability resources based on functional support needs rather than diagnosis – Access, eligibility, payment, service availability, cost caps, age requirements or gaps.	• Create a consolidated waiver for adult individuals who are aging or adults with physical disabilities that would blend existing waivers with expanded services to better meet the needs of people under the age of 65 • Make access to services and processes simpler, easier to understand and navigate • Increase understanding of Medicaid policy and spousal protections available under waivers • Address current discrepancies in rates for similar services • Eliminate waiting lists for services • Establish a seamless quality improvement strategy across waivers • Establish methods to share practices across target groups and programs to encourage and facilitate use of best practices across the system	• System baselines were established for the following: — HCBS system performance (were the most robust segments of the system meeting needs or over-serving?) — Unmet needs (for individuals currently enrolled or awaiting waiver services) — Capacity (providers, State oversight, etc.) — Current processes (including process time/effort) and standards (access/eligibility, including cost caps) — Current complexity • Deliverables and timeframes for waiver consolidation and improvement were identified • System performance: Quality for individuals receiving service improved • Unmet needs decreased • Institutionalization or re-institutionalization of individuals eligible for HCBS demonstrated downward trends or delays in institutional utilization • Comprehension of all system facets increased: Eligibility (including protections for spouses in the community), access, services, providers, consumer protections and safeguards • Comparable rates for similar services rendered by similar providers were established • A seamless quality improvement strategy was

Strategy	Tactic	Metric
		established and in place
Close service gaps and improve existing services or identify new services to better serve the needs of all populations. Assess access to other services critical to success in community living.	• Undertake comprehensive review to ensure adequate, appropriate service availability within HCBS waivers and State Plan (all services needed to support individuals in the community). For example: – Review and expand chronic disease education and self-management programs with a focus on geriatrics and supports for aging individuals – Increase and improve physician access and physician understanding of community capacity to meet individual needs – Increase and encourage greater use of peers or caregivers in the delivery of service – Identify strategies to expand and grow successful, person-centered, affordable assisted living communities – Simplify and better inform individuals on availability of home modifications – Improve and promote importance of employment services (and discredit related eligibility myths) – Improve care transitions and care management	• Baselines across all populations (using available service array and utilization patterns) were established • Services that demonstrated improved community retention or return (using available national data) were incorporated into the program

Strategy	Tactic	Metric
	— Identify strategies to utilize HCBS as a tool to prevent or delay institutionalization.	
Create mechanisms to ensure quality in the care provided through HCBS	• Review and incorporate strategies employed within Connecticut and across the nation to ensure sound discovery and remediation techniques to identify and fix issues quickly within the community. • Use information gathered from discovery and remediation efforts to continually improve systems and operations	• Strong performance on established outcome-based performance measures
Build, improve and make provider networks accessible to wider array of individuals.	• Provide education around informed risk parameters and person-centered strategies for risk mitigation • Change legislation to allow for reduced liability to agencies who may be caring for individuals with significant support needs and who seek to undertake some informed risk beyond the care typically provided by the agency • Review and improve medication administration regulation and training in an effort to enable wider opportunities for the use of medication administration technicians across all settings. Pay rates to enable livable wages and benefits (commensurate with NF pay and benefit levels)	• Baselines for providers of HCBS were established including: — Existing availability across waivers, measured over time, for increased capacity and quality • Legislation to address medication administration and risk/liability issues for HCBS provider entities was proposed • Consistent or reciprocal provider qualifications across all waivers were established and in place • Payment for similar services across the service system were aligned • Methodology to ensure provider quality was seamless and consistent across provider entities was developed

Strategy	Tactic	Metric
	• Cross-train and align provider qualifications across waivers and the continuum of care so that one provider can offer a package of services to all who need it • Ensure quality of care through independent evaluation of provider — Identify strategies to support providers who care for complex and high-risk individuals to encourage, rather than discourage, provision of care with significant support needs — Ensure disaster preparedness, establish partnerships to meet individual needs in emergency situations/circumstances	

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS system, have a direct impact on the ability or timeliness of possible implementation.

1. Affordable, accessible housing: Individuals are only able to avail themselves of HCBS if they are able to secure or retain housing in the community.
2. Fiscal considerations: Changes to rates and services (amounts, duration and scope) will have fiscal implications. Quantifying these considerations and identifying available resources will be key to moving forward.
3. Conflicting regulations between Medicare and Medicaid: Issues requiring resolution include formulary coverage or gaps for pharmacy benefits, disparate requirements for home health, homebound and others.
4. Transportation challenges: Availability of transportation as well as inability of personal care providers to provide transportation.

5. Availability of standard assessment that identifies needs objectively, based on need not diagnosis, and streamlined tools for service initiation and data collection.
6. Disparate rates and provider requirements across existing waivers. While noted above as an issue to address, changes will require engagement and negotiation with wide array of providers and individuals served.
7. Lack of disaster preparedness strategies such as utilization of NFs to house and care for consumers when provision of HCBS services is not possible due to short-term catastrophic events.

Other strategies

The strategies noted above represent those identified by the group as being the highest priority; however, other critically important steps and considerations were raised during this dynamic stakeholder retreat. The items noted below should be addressed as a part of the broader overall strategies addressed above or should be sequentially addressed once the broader strategies have been implemented:

1. Deliberately incorporate employment discussions/plans into all service planning discussions with people seeking services.
2. Undertake deliberate, comprehensive support efforts for informal caregivers: Education, support services, respite, linkages with peers, etc. Expand understanding of existing informal caregiving network (and its likely expansion with expanded HCBS utilization).
3. Provide one-stop shopping or informed choice about all resources available across populations/communities (no wrong door approach). Aging and Disability Resource Centers (ADRCs) have been helpful but many people are not yet aware of ADRCs and these are not available across the State.
4. Provide comprehensive, concise education of providers, families and potential service recipients of what is available and how to access it.
5. Increase access to advocacy and protection while residing in the community. Ensure quality of care.

Workforce

Overview

As the State begins to operationalize its efforts to right-size its LTC services between NFs and HCBS, there are many important issues to consider. Chief among them is assessing the workforce capacity as a result of rebalancing the delivery system. As demand for HCBS services increases, the demand for paid and unpaid direct care workers will also increase. Between 2006 and 2030, the population over the age of 65 is expected to increase by 64%, while the working-age population is expected to decrease by 2%. This gap will decrease the supply of informal caregivers as well as the pool of direct care workers. Understanding and leveraging the informal caregiver supply while making the direct care field an attractive option for job seekers is a key component of LTC rightsizing. As Connecticut aggressively pursues Medicaid rebalancing goals, the need for focused efforts to recruit, train, retain and support paid and unpaid caregivers is essential. Without a focused, coordinated approach, lack of caregivers will stall rebalancing efforts and Connecticut will fail to meet its goals.

Goal: Attract and support paid and unpaid direct care workers. Increase the direct care workforce to adequately supply the future demand for LTSS. There are expected to be 24,000 LTC users over the next 15 years, with the majority of users receiving services and supports in their homes and communities.

Strategies

Strategies	Tactic	Metric
Recruit new direct care workers, retain existing direct care workers and support unpaid caregivers.	• To attract more workers, reform the pay structure, including benefits of LTC industry workers. Develop incentive packages that may include housing and transportation options. • Increase connectivity, networking and training among paid and unpaid caregivers. Use model mentoring, peer support, support broker and employer training programs to provide networking, support and education to direct care workers, consumer/employers and unpaid caregivers.	• Began formulization of incentive packages and identified funding. • Authorized the use of peer supports and support brokers/employer supports as a service of Medicaid HCBS waivers. • Developed mentoring pilot programs.
Review, analyze and change (as necessary)	• Create equity across State systems.	• Completed analysis of state systems

Strategies	Tactic	Metric
the infrastructure that affects the direct care workforce.	Review, analyze and catalog similarities and difference across State agencies' programs, policies, regulations and practices that affect the direct care workforce (i.e. training and support, consumer direction, wages, unemployment insurance and workers' compensation). • Develop a local repository or clearinghouse that provides opportunities for linkages at a local level and allows consumers to identify providers of services and supports. • Restructure the waivers to allow for a more streamlined approach of entry into the HCBS waiver programs and to provide for a more uniform approach for the access of services.	• Dependent on analysis, sought regulation and legislative changes to equalize the system • Developed a local repository
Provide training and supports for providers, employers and unpaid caregivers	• Foster training and re-training programs for direct care workers. Collaborate with the community college system to design direct-care curricula using a foundation of person-centered care. • Develop career pathways and career lattices for direct care workers. • Identify model re-training programs that would allow the existing pool of institutionally-based paid direct-care workers to be trained to provide services and supports in the community. • Develop a marketing plan to make others aware of the opportunities for	• A proposal to partner with existing and new educational outlets in response to the need for education of the workforce (new, existing and future). • Enrollment and post-training job statistics tracked and demonstrating a dwindling gap in workforce needs • The number of new workers increased from X to Y

Strategies	Tactic	Metric
	direct care workers. Marketing plans may focus on the flexibility of the job and target potential workers seeking this type of flexibility (e.g., parents, college students). • Offer mentoring and peer support to formal and informal caregivers.	

Challenges to success

Development of a LTSS workforce that is sustainable, respected and skilled is critically important for the State's right-sizing initiative to be successful. Although not insurmountable, there are some challenges that must be overcome for successful execution. These challenges have direct implication for the timelines in meeting the State's right-sizing goals.

After discussion about the primary challenges for success identified by the group, two basic issues were identified. First, the Connecticut waiver structure and second, the policies, regulations and practices in State agencies that do not support dignity, choice and autonomy of individuals with disability and older adults. These issues were viewed to seriously hamper the ability to achieve a more efficient and standardized structure and workforce. In short, the workgroup felt that a systemic review of the policies, procedures, regulations and practices across State agencies, with the goal of creating more equity across systems, could result in greater workforce efficiencies. If these systemic issues cannot be examined and rectified at the State level, workgroup participants felt there would be little that could be done to meet the demand for an increased workforce.

In addition, participants agreed that another challenge to meeting the workforce demand included the economics behind living in Connecticut where the cost of living compared to the wage earned presented a unique barrier. The current HCBS pay structure does not offer enough incentives to attract new workers. While the group also identified the supply of adequate housing and transportation for workers as a challenge, the group feels that the influx of workers as a result of pay reform will spark subsequent movement in housing and transportation.

Other strategies

As noted earlier, many of the distinct features and challenges within the system have elements that are interrelated, and in some instances, interdependent. The group discussed the impact of housing and transportation on workforce development; however, the discussion remained targeted on workforce development.

The MFP demonstration has a Workforce Development workgroup that has been developing strategies for two years on home and community-based workforce development. The MFP workgroup had many participants that also took part in the strategic right-sizing breakout group. The MFP Workforce Development workgroup has a comprehensive strategic plan entitled “Direct Care Workforce Development – Strategic Plan” that includes vetted goals and action steps. Through engagement and support of this committed statewide workgroup DSS will ensure unduplicated efforts, strengthen established partnerships across LTC, education and workforce sectors and solidify messaging.

Housing and transportation

Overview

Housing

Provision of affordable, safe and accessible housing plays a critical role as Connecticut assists Medicaid consumers to either remain in or return to the community. Appropriate housing opportunities for HCBS consumers can vary greatly and are frequently the primary barrier for LTC consumers to receive HCBS. In order for the State to accomplish its LTC right-sizing goals, it will be necessary to have an adequate supply of housing so the established rebalancing targets may be accomplished.

Housing options include a person's own home (owned, leased, shared), supportive housing, shared living arrangement, congregate housing, assisted living services/managed residential communities and residential care homes. Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community.

Transportation

Transportation becomes central in providing Medicaid consumers access to the community. Additionally, transportation plays a pivotal role in bringing caregivers to HCBS consumers in order to provide the care needed for consumers to successfully remain in or return to the community. Transportation is frequently acknowledged to be one of the greater unmet needs in communities. Transportation (when available) is frequently not accessible or affordable, leading to additional challenges to bring the consumer and the service providers together.

Strategies

Strategy	Tactic	Metric
The State should foster greater partnership and cross-agency collaboration between agencies focused on housing and transportation.	Establish a strategic partnership between DSS, Connecticut Housing Finance Authority (CHFA), Department of Economic and Community Development (DECD)/Office of Housing Development & Finance (OHDF), Department of Transportation (DOT) and the US Housing and Urban Development (HUD) DSS should establish a housing and transportation unit to specifically build relationships with partners in order to increase available units and resources for housing and transportation Leverage new relationships to access additional housing vouchers via grants and identify project-based housing units that are currently vacant for housing of transitional clients Foster collaboration with DOT to establish different guidelines for caregivers providing transportation which leads to an increase in pay	A formal partnership between DSS and HUD, DECD/OHDF, CHFA and DOT established A housing and transportation unit within DSS established Available housing options from X to Y expanded Guidelines to allow caregivers to provide transportation revised

Strategy	Tactic	Metric
Provide natural supports and caregivers with transportation and housing assistance	Provide caregivers and clients priority with tenant-based and project-based housing vouchers as well as help to establish community coalitions to assist in transportation Analyze additional means to establish how home sharing could assist family and caregivers with respite Establish coalitions for community transportation to assist with ride shares Explore the use of Zip car-like rentals service Explore the use of school buses during the day Develop more opportunities to utilize the 202 housing program to assist in housing shortage	Workforce survey on perceived transportation barriers improved from X to Y Expansion of shared housing increased from X to Y Ride share use increased from X to Y 202 housing units increased from X to Y
Preserve system funding that is the result of savings from rebalancing by allocating funds specifically to housing and transportation.	Establish a housing trust to hold funds from cost savings of transitions in order to reuse savings specifically toward housing and transportation instead of allowing funds to go back to the State's general funds	Calculated savings placed in trust improved from baseline to X%
Improve financing dollars for housing.	CHFA to obtain new bonding dollars for affordable housing and to the extent permissible under the funding stream, to allow NFs to modernize and introduce culture change and for capital improvements/conversions (e.g., greenhouse concepts, home-like environments, more common space, designs for more space and environmental efficiencies)	Bonding funds increased from X to Y

Strategy	Tactic	Metric
Convert select NFs to assisted living.	Support the development of assisted living communities through the conversion of skilled nursing home buildings and on the campuses of skilled nursing homes	X many conversions over Y many years

Challenges to success

During the course of discussion the workgroup observed the following challenges to affordable housing and transportation:

1. Current housing options require significant retrofitting/restoration.
2. There is considerable fragmentation between State agencies such as DOT, DSS, CHFA and DECD/OHDF.
3. There is a lack of data preventing an understanding of issues by geography.
4. There are considerable regional differences throughout the State related to housing needs.
5. Transportation is not available for the community workforce to reach clients.
6. The bias against assisted living and campus of care settings in MFP grants.
7. Housing requires considerable development funding and the operating subsidy for the actual affordable housing site which requires a federal and State collaborative effort.

Other strategies

The follow-up comments supported the following additional strategies:

1. Foster and improve ability to use assisted living communities.
2. Expand and develop the State's current affordable housing with assisted living models and pilots (congregate, HUD 202 and the demonstration pilots).

Hospital discharges

Overview

Hospital discharge planning activities often drive patients to NFs in order to provide a safe discharge environment and act as an effective mechanism in transitioning consumers along the continuum of care to ensure that they receive the appropriate follow-up care and services they require. For Medicaid participants discharged from a hospital to a nursing home, the risk of long-term institutionalization is significant. Data shows that 65% of all Medicaid participants who enter NFs are still there after months.[8] Thus, for vulnerable populations, entry into a NF can often lead to permanent institutionalization and loss of community ties and individual freedom of choice. Additionally, health services research indicates NFs could provide viable alternatives to acute inpatient admissions/re-admissions, effectively bypassing emergency departments (EDs) (structured carefully to ensure adherence to all federal and state service provision requirements) and subsequent inpatient stays through direct NF admissions. From this perspective, NFs can ensure that patients receive the right care in the right place at the right time and can be quickly transitioned back into their community.

The strategies outlined below represent those steps the Hospital Discharge workgroup identified as being critical in the State's efforts to promote more efficient and effective hospital discharge planning processes. Through more integrated and streamlined processes and with greater collaboration and education, it was felt that more effective transitions of care could be obtained, recognizing the non-delegable nature of the function for hospitals. Thus, as consumers need to access acute care services, hospital case managers, assistive personnel and physicians could (1) promote home- and community-based support and service alternatives when appropriate effectively reducing potentially inappropriate NF admissions that can lead to long-term institutionalization, and (2) target and reduce inappropriate ED and subsequent inpatient admissions through either a direct NF admission process or home health service delivery options.

[8] Connecticut Commission on Aging Strategy Paper, December 2010, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.cga.ct.gov%2Fcoa%2FPDFs%2FFact%2520Sheets%2FCoA%2520LTC%2520strategies%252012-7-10.pdf&ei=WIThTt2NLKHm0QG_mdCJBg&usg=AFQjCNFzEWtVJVgGcjMgOiDc5Rs0NHNTzw&sig2=1HNf3nqhsWUNuxCZBopnlQ, last accessed December 9, 2011.

Strategies

Strategy	Tactic	Metric
Convene a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health (PH) and behavioral health (BH) issues.	Develop statewide definitions for key HCBS terms such as "choice", "person-centered plan" and "dignity of choice" that will drive cultural change Devise and implement a global communication plan raising awareness of LTC options Continue to build on a centralized, web-based repository for LTC information, making it meaningful and relevant to the medical/hospital community Develop strategies to promote electronic health records LTSS settings (NF and HCBS). Note: Such providers were not among those eligible for federal electronic health record funding and incentives, so other strategies for funding and/or incorporation should be explored. Build greater synergies between the various State, regional and city organizations that all have a role in promoting LTC and HCBS options	Established systems baselines: What was the hospital community's understanding of HCBS options? What barriers existed for hospital case managers in promoting HCBS options? How could the current pre-admission screening process have been revised to promote options for HCBS? Were there screening tools that could have been employed to better stratify at-risk individuals? Assessed current fragmentation or available options in obtaining services for individuals with BH conditions Satisfaction measures related to knowledge, resources and ability to access services by the health care community Satisfaction measures related to knowledge, resources and ability to access service by consumers Number of "hits" on centralized website Employed survey for individuals accessing the website Used data to re-design/update web content as appropriate

Strategy	Tactic	Metric
Develop and implement a Transition of Care model specific to individuals who are receiving or are at risk for receiving LTC services. Specifically, it is key to build the bridge from the hospital discharge to the community and strengthen the hospital ties with community resources. (Note: This was viewed by the workgroup to be a separate strategy to be employed in tandem with the Person-Centered Community Care Collaborative)	Improve collaboration to develop more definitive “handoffs” between hospitals and community resources. Coordinate all efforts of this type within the State to ensure maximum coordination and collaboration. Develop and deploy a comprehensive educational program targeted at hospital case managers and hospital physicians that provides information on the options available to care for individuals in the community setting and assists the medical community in becoming more person-centered and less paternalistic. Web-based training program globally accessed by all hospital case management staff providing basic training on LTC options Increase and improve understanding of key HCBS terms and how that effects care planning and discharge efforts Implement a tool that assists hospital case managers in determining at-risk patients for LTC services Tool could be web-based and algorithmic, allowing for LTC options to be displayed based on what the individual’s needs were, promoting individualized and person-centered planning Hire and train LTC ED coordinators who could be responsible to more effectively identify and engage resources to assist in transition of a person back into a community setting or minimize the length of stay in a NF through effective care planning Build on work currently underway relating to the transition model of care as well as develop a cohesive approach that encompasses various State initiatives currently underway such as the dual eligible integration initiative	All measures were for those individuals, new or existing, that received LTC services: Readmission rates To hospital from community To hospital from NF To NF from community To NF from hospital For those who required LTSS upon discharge from hospital, X percent increase in discharges to community versus institutions Reduction in length of stay (LOS) Acute inpatient LOS NF LOS The overall community tenure of individuals who received HCBS services increased Standardized discharge planning survey assessed: Patient/caregiver understanding of discharge plan Support in successfully implementing the discharge plan and engaging LTC services Timeframe for follow up with primary care provider or specialty care provider post discharge Understood long-term options that were available to the consumer

Challenges to success

Whether the strategies identified above are undertaken individually or as a package for comprehensive HCBS system reform, there are some challenges that must be overcome for successful execution. These challenges, though not unique to the efforts to ensure a rich HCBS system, have a direct impact on the likelihood or timeliness of implementation:

1. In addition to cultural and attitudinal barriers that require education and dialogue to overcome, the State/Department of Public Health regulations may not have kept pace with the times:
   a. The medical concept of a "safe discharge" is often at odds with the community-based mantra of "dignity of choice", making the necessary health care community's culture change to support rebalancing difficult.
   b. The ability to obtain physicians orders for services outside of a hospital or clinical setting is a challenge to ensure that the individuals receive the most array of services within a timely fashion.
2. Medicaid and waiver structure:
   a. When trying to coordinate service planning for individuals with BH issues, provider qualifications and low reimbursement rates make it difficult to recruit and retain providers (i.e., mid-level mental health (MH) nurse practitioners are not recognized by some waivers as viable providers of service).
   b. Disparity in provider reimbursement between PH and their MH counterparts undervalues the provision of MH services.
   c. The varied structure, service packages and eligibility process make accessing services difficult and those delays contribute to institutionalization and then the 90 day wait period for MFP options starts and delays community discharge even further.
3. The Centers for Medicare & Medicaid Services (CMS)/federal regulations:
   a. The Medicare regulation for a three-day hospital stay (with "traditional" Medicare) precludes direct SNF admissions. Observation stays do not count as admissions; therefore, they do not count towards a three-day hospital stay.
   b. The definition of "community setting" makes it difficult for LTC providers wishing to diversify their business model to enact timely and efficient change to their service delivery array (e.g., certain assisted living arrangements may not qualify for MFP grants).

Nursing facility diversification and modernization

Overview

The current State LTC institutional landscape includes 238 NFs with a total of 28,780 beds and an average occupancy rate of 92%. The State ranks number three in the country for the number of facility residents per 100 State residents over age 65, at 5.8 compared to the national average of 3.8. The State also has ranked high in the proportion of low-acuity residents that live in NFs. According to data from the CMS *2008 Online Survey, Certification and Reporting* database, the average ADL score of a Connecticut NF resident was 3.7 while the national average was 4.0. Four states tied with Connecticut and only two states had a lower acuity score, demonstrating Connecticut's opportunity to transition or maintain more individuals in community settings.

NFs are a critical component to any state's Medicaid LTC program. Recent studies, however, conclude that consumers increasingly want to remain or return to their own homes.[9] In response to consumer desires, the State has implemented initiatives that are designed to result in an increased proportion of the Medicaid LTC consumers residing in the community. Regardless of this shift to providing supports and services for consumers to remain in or return to their communities, NFs will continue to be a vital component to any LTC program. NF operators will however need to consider what their presence in the local community will look like in the future: Will it be a smaller facility? Will it provide specialized care? Will it be an operation that also provides supports and services to consumers who reside in the community?

This group was tasked with identifying different strategies NFs might consider in order to diversify and modernize their health care operations so that they may effectively react to the changing LTC environment.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a home- and community-based setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule.

[9] Connecticut Long-Term Care Needs Assessment Part I: Survey Results, June 2007 (REVISED March 2010), Page 56, Table III-10.

Strategies

Strategy	Tactic	Metric
Transform NFs into comprehensive assessment centers for all LTSS.	• Adoption of a common assessment tool or common assessment elements that address all LTSS and related conditions and disabilities. The tool should be person-centered, include collaboration with hospital discharge planners and MFP initiatives, and consider available community resources and make recommendations when community supports are lacking. • Redefine the Certificate of Need (CON) process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports the transformation process. • Determine a payment rate for the assessments and how such payments will be funded. • Change community interaction (e.g., communication channels, means of obtaining information, requests for assistance, grievances, etc.) with NFs to support person-centered care.	• Identification of a single assessment tool • Number of assessments • Number of referrals for community-based services increased from X to Y • MFP payments for development of an assessment tool or conversion of NF building/ operational/workforce to assessment centers • Consumer surveys on the role of NFs and HCBS in their communities • Revision of CON policies and procedures • Payments for assessments at the State level, including MFP payments • Revenue and units of service for assessment at the facility level • NF operational changes reflecting focus on person-centered care • Ombudsmen surveys
Develop NF services to include transitional programs that support the movement of individuals from a variety of care settings back into the community.	• Expand Medicaid- and Medicare-covered therapies to support rehabilitation and training for community living (e.g., occupational therapy, etc.) • Create additional transitional training programs within NFs (including possible transitional units), including training and support for caregivers	• Changes to Title XIX and Title XVIII supporting community living therapies • Revenue/billed units for identified therapies • Repurposed square footage to support transitional programs • Revenue/billed units for identified services • MFP payments for development of

Strategy	Tactic	Metric
	• Revise NF licensure and regulatory requirements to allow for transitional programs and new levels of care (LOCs) • Develop Medicaid rates for transitional services • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports transitional services • Coordinate with other integrated care and home health initiatives	transitional programs or NF building/ operational/workforce changes for addition of transitional services • Number of educational programs for caregivers • Consumer surveys • Changes to Title XIX and Title XVIII supporting transitional living services • Statutory and regulatory revisions • Medicaid (or MFP) fee schedule or rate methodology for transitional services was developed • Revision of CON policies and procedures
Transform NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity.	• Reissue business plans and financial projections, such as those supporting financing arrangements, debentures and investor communication (i.e. annual reports, board meetings, etc.). • Provision of community-based services through NFs, including but not limited to therapies, home health, personal care, home-delivered meals, hospice (facility and home), respite, memory impairment, transportation, concierge, adult day and assisted living, etc. This concept reflects the MFP ideology of care following the person and the caregiver following the person, regardless of setting. Facilities will become similar to alcohol and drug recovery centers and centers for coordination and support	• MFP payments for strategic assessments/feasibility analyses and development of business plans • Number of business plans that include continuing care programs • The number of non-NF services provided by NF entities • Non-NF revenue paid to NF entities • Non-NF individuals served • Changes in licensure of NF square footage • Changes in licensure allowing hospice services in individual rooms within a NF and coverage by Medicaid/Medicare • MFP payments for development of community-based services or NF building/operational/workforce changes for

Strategy	Tactic	Metric
	• Development of community space at NFs • Redefine the CON process for determining how NF space can be used for non-NF services, including de-licensure, so that it supports community services	addition of community services • MFP or other grants for development and implementation of electronic health records for LTC services • Consumer surveys • Changes in licensure of NF square footage • Revision of CON policies and procedures

Challenges to success

The current bias for NF care has evolved based upon historic Medicare and Medicaid policies, which have then influenced a host of other issues, including workforce development, financing, licensure/certification and other federal and State policies. For the above strategies to be successful, action will be needed to revise how LTSS are typically provided, including challenges inherent in the current system such as those listed below:

1. CON policies and decisions that restrain the transformation of NFs or deter closure/de-licensing of beds, including outdated moratorium statute.
2. Lack of funding for development and adoption of a single assessment tool that reflects person-centered planning. Note: In such efforts, the State should consider how and/or if such an assessment relates to the Minimum Data Set.
3. Lack of or insufficient funding for assessment payments; rates too low to support such services.
4. Coordinating BH and substance abuse services with LTC assessments and services.
5. The three-day hospital stay requirement under Medicare, which limits NF utilization in place of hospital services.
6. Resistance to changes in revenue projections and business plans that may require the approval or notification of financing entities (e.g., mortgage holders, bond trustees, banks, etc.).
7. Funding for building and property changes to support comprehensive assessment services and adequacy of revenue to support costs of such changes.
8. Resistance to changes in hourly rates, job classifications and available positions that may require approval or negotiations with the Service Employees International Union.
9. Funding for training and workforce development for comprehensive assessments, transitional and other community-based services.
10. Lack of coordination with other MFP initiatives, resulting in competition and duplication of services and costs.
11. Lack of changes to statutory and regulatory governance of Medicaid (Title XIX), Medicare (Title XVIII), CON and licensure programs to support transitional services and mixed-facility use.
12. Lack of funding (MFP, Medicaid or Medicare payments) for transitional and community service development (e.g., direct funding, loan guarantees, etc.).
13. Lack of inclusion of occupational therapy as a covered MFP, Medicaid and/or Medicare service.
14. Coordination/collaboration with existing HCBS providers and financial viability of new and existing services.
15. Need to ensure ability to provide enhanced hospice services delivered within NFs (or space formerly used for NF services).
16. Lack of funding (federal grants, MFP funding, etc.) for LTC providers for electronic medical records.

17. Continued use of nursing homes for care prior to Medicaid eligibility determinations and rendered without compensation (exacerbated by challenges with timely eligibility determinations).
18. Adequate resources (i.e. payments, trained staff, etc.) for higher acuity care within nursing facilities as the rightsizing initiative moves forward.

Other strategies

Strategies that were discussed but considered lower priorities than those identified above:

1. Add other community services at NFs to make them more attractive for community involvement.
2. Support coordination between NF and other HCBS so the NF is a community backup when other HCBS providers have difficulty meeting individuals' needs.
3. Enhance NFs as centers for community and family support for LTC services and education rather than as the last and least desirable option. Focus should be on the individual's needs and desires and how to coordinate those needs and desires within the community and family.
4. Allow NFs to "think outside of the box" and develop use of beds for services other than LTC Medicaid stays.
5. Encourage the establishment of a more collaborative and flexible approach to regulation and reimbursement with both the funding and the licensing agencies working together to encourage innovation.
6. Consider a variety of uses for nursing home beds such as short-term rehabilitation, overnight respite, emergency shelter, and specialized service units.
7. Modernization of nursing homes to create physical sites reflecting the nursing home of the future. Modernization efforts to create the systems and services that are desired by consumers and which are required in the new system of health care reform. Greenhouse models, culture change modifications, energy efficiencies, electronic health records, transportation systems, and other capital improvements should be encouraged throughout the system of grants, loans, reimbursement and funding.
8. Promote, including the availability of resources, electronic records for LTSS.
9. Conversion to assisted living beds, even if not paid for by the Medicaid/MFP programs.
10. Reduction of the nursing bed supply via a multi-pronged approach which might include permanent bed reduction through a temporary bed reduction through a mothballing or reclassifying bed use, the relocation of beds, and other options for the right-sizing and redistribution of bed supply throughout the State.

4

Money Follows the Person grants

Overview

As the State moves forward with its LTC rebalancing initiatives, there is no doubt that the State's LTC system will look very different in the future. To assist in this transformation effort, the State has secured approximately $20 million in funding from CMS so that "institutions will begin to redefine their role in the delivery of LTC from 'final placement' to an environment that supports long-term living". This funding will provide the opportunity for financial assistance to NF providers that desire to transform their current business model in a way that will expand the opportunities for individuals to reside in the community setting of their choice.

The State will develop grant opportunities for the planning and implementation of LTC right-sizing initiatives for which NF providers may apply. In order to evaluate proposals and fund diversification plans the MFP Grant workgroup was tasked with developing strategies to assist the State in issuing a request for grant proposals. The MFP Grant workgroup was also tasked with developing guiding principles and criteria that the State could use to evaluate and fund the various plans that may be submitted.

Per the State's current MFP Operational Protocol (revised February 10, 2011), this funding will be divided into two phases: Phase I for planning activities for potential diversification and Phase II for funding viable plans that the State selects. The funds for Phases I and II will be targeted to NFs interested in diversifying their operations by providing community services or serving in another capacity that supports the successful provision of services to individuals in the community while also decreasing the number of NF beds. Phase II funding may go towards paying a NF for each person they return to the community in order to compensate the entity for its effort to support the individual during the transition. Funding from Phase II can also be used for infrastructure costs associated with the development of a HCBS business model. Examples of infrastructure costs CMS grants can cover include:

- Technical assistance/consulting
- Legal fees for establishing a separate home health agency structure and other start-up costs
- Fees for becoming a certified adult day provider
- Business interruptions costs during conversion

- Licensure costs
- Meetings costs
- Infrastructure costs associated with information technology
- Training and professional development
- Travel
- Community market research
- Outreach activities
- Print materials for adult day center or home health agency

In addition, for facilities wishing to develop community housing, expenses attributed to accessibility modifications can be covered; however, costs associated with renovating on institutional grounds for the purpose of creating housing on institutional grounds will not be covered.

If the final MFP grant program differs from what the current MFP Operational Protocol would allow, the State may amend the current protocol to align with the program adopted by the State and request CMS approval.

Note: CMS has proposed rules regarding what conditions must be met to qualify as a HCBS setting (e.g., assisted living). What impact that may have on options for NF operators who wish to diversify is not fully known at this time since CMS is reviewing a significant number of comments before it can finalize the rule. This proposed rule is separate from, but related to, the statutory requirement that qualified community settings for MFP include no more than four unrelated individuals residing together. CMS has provided guidance to MFP grantees on how assisted living may be considered to meet those requirements.

Strategies

Strategy	Tactic	Metric
Determine the interest of NFs regarding grants for planning and implementing LTC right-sizing initiatives.	• Develop a survey and survey NFs regarding their interest in grants for planning and implementing LTC right-sizing initiatives; questions could include but not be limited to interest in grants, interest in receiving technical assistance, type and amount of planning that has already occurred at the nursing home, and what would be appropriate amounts for grants; this information can be used to determine how the grant funds should be allocated between Phase I and Phase II	• Survey developed • The number of NFs that completed the survey • A report that summarized the results of those NFs that completed the survey
Inform the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives.	• Develop a training module to educate the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives • Educate the NFs about the opportunities to apply for and receive grants for planning and implementing LTC right-sizing initiatives; provide these through one or more of the following: — Meetings — Webinars — Web page	• Training module developed • The number of education meetings and webinars, including the number of participants and locations of meetings • A webpage where all information about the grants and background material on the LTC right-sizing initiative is accessible was developed
Make technical assistance available to NFs in preparation for submitting their proposals for planning grants and implementing LTC right-sizing initiatives.	• Arrange with CMS MFP technical advisory contractor to provide 1:1 technical assistance with NF providers who want to submit proposals for planning grants and implementing LTC	• The State established formal arrangements for 1:1 technical assistance • The number of NF providers that received 1:1 technical assistance for planning grants

Strategy	Tactic	Metric
	right-sizing initiatives • Consider additional methods to obtain feedback on submitted provider plans	• The number of NF providers that received 1:1 technical assistance for implementing initiatives
Provide to NFs grants for planning and implementing LTC right-sizing initiatives.	• Develop and issue a grant proposal that is based on the input provided at the State's LTC Right-sizing Strategic Planning Retreat, a utilization and cost-projection model to identify where grants are needed, NF survey results and any other comments that the State may receive from providers, advocates and others • Develop the associated data that can be used by NF providers in preparing for their grant proposal and also utilized by the State in the evaluation of proposals	• A grant proposal was developed and issued • Data was available for use by the NF providers and the State (data and other right-sizing-related documents made available on a State website/page) • The number of NF providers that submitted proposals and received planning grants; included the amount requested and amount awarded • The number of NF providers that received grants for implementing initiatives; include the amount requested and amount awarded • The number of home health agencies created • The number of NFs that provided emergency back-up support in the community • The number of affordable housing units created • Increased percentage of Medicaid LTC participants living in the community compared to institutions

Guiding principles and evaluation criteria

The MFP grants workgroup identified several principles that the State should follow when developing the MFP grant proposals and awarding grants. The final plan should include agreed upon guiding principles such as the following:

1. The criteria must align with the State's LTC right-sizing strategic plan and MFP operational protocol.
2. The MFP grant expectations must align with the funding that is available.
3. The evaluations criteria should be transparent. In other words, providers should know exactly how they will be evaluated and what priorities the State will establish when awarding a grant (i.e., one region versus another region of the State, two NFs with equal proposals).
4. There should be the ability to skip Phase I (planning) if the provider has already completed their planning without any funding. This would require the State to issue Phase II opportunities should they be made available. Don't delay Phase II for providers.
5. The grants that are made available should be based on regional needs and not on statewide criteria.
6. Criteria for the evaluations must align with needs of the community.
7. Facilities should develop relationships with and partner with existing HCBS providers/agencies.
8. Phase I planning grant criteria should be more flexible than Phase II implementation of LTC right-sizing initiatives.

The MFP Grants workgroup believes that before the grant proposals are developed, in addition to the guiding principles, there should also be a list of basic evaluation criteria to guide the authors of the grant proposal. The workgroup identified several criteria that should be considered when establishing how grant applications will be evaluated. The following is the list of evaluation criteria discussed within the workgroup and offered for the State's consideration:

1. The provider should be able to demonstrate that they have been in compliance with State licensure and CMS certification requirements.
2. A NF's low occupancy rate does not mean that they would have a higher priority for receiving a grant.
3. A provider should be able to demonstrate its successes with its current NF workforce.
4. A quality provider should not necessarily have to reduce its beds if their grant request demonstrates the ability to meet a community need.
5. A provider's demonstration that their project has an established need in the community.
6. A provider must demonstrate that it has supported efforts to inform consumers of their choices (informed choice) regarding all LTSS that are available.
7. A provider's demonstration of its support of and competency at delivering a person-centered approach to providing LTSS.
8. A provider's demonstration of how it has undergone or begun to undergo a culture change in their NF (e.g., Greenhouse).
9. A provider's demonstration of its financial viability.
10. A provider's demonstration that its proposed project is sustainable.
11. A provider's demonstration of how its project will be aligned with the other community providers and supports (e.g., Memorandum of Understanding to demonstrate a commitment to collaboration).

Data

MFP grants will be targeted towards alignment of estimated demand for LTSS, including the NF bed supply. NF bed supply will be addressed through grant incentives to adjust capacity where needed. NF bed capacity will be decremented by grant awards for those providers who seek the opportunity. The State will take a pragmatic approach in grant evaluation.

Numerous workgroup members discussed the need and desire to have a more robust dataset to understand and analyze the effects of rebalancing. To address that need, the State is in the process of establishing a “live” data book for the primary purpose of providing reliable data on which the State can base decisions to ensure the appropriate balance of supply and demand. While the NF bed supply will be adjusted primarily through grant incentives and the development of additional HCBS capacity, decreasing NF bed utilization will likely impact the delivery of LTSS in many ways, including ones that are significant and unpredictable at this time.

The data book may be used by the NF providers who may submit grant proposals to ascertain information regarding capacity within their area.

The next phase of development of the strategic plan will consider how the data, maps and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information (in conjunction with the experience of providers and local communities) will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but regular evaluation should provide an appropriate context for determining next steps in the process.

The data book will be located on a Connecticut DSS webpage: http://www.ct.gov/dss/xxxxx. The data book will be refreshed on a minimum of a six-month basis so that it can be relied upon as a valid source of information. The State will also be adding additional information that might be useful to NF providers, the State and others.

The current data book will have the following information available:

- NF performance and rates matrix. (This document includes individual information on all Connecticut NFs. Some of the information included is regarding the number of registered nurse hours per resident day, quality measures star rating, overall star rating and percent of beds occupied.)

- Maps that show the location of NFs, residential care homes, assisted living services agencies, home health care agencies and homemaker/home health aide agencies. These maps are by county and also include regional population density information.
- Maps by county that show the locations and bed size of NFs and residential care homes.
- Maps by county that show the occupancy rates of NFs and residential care homes.
- Several NF and residential care home bar charts that indicate type of ownership (e.g., for profit – not multi-ownership), number of beds per facility, percent of beds occupied, rates (per diems) ranges and overall star ratings.

Challenges to success

There will be challenges in developing a fair and comprehensive MFP grant request for proposals. The development of this document will be guided by the principles and evaluation criteria noted above. A fair and comprehensive document can be developed by also understanding some of the challenges related to the MFP grants. The challenges that were identified by the MFP Grant workgroup include but are not limited to the following:

1. Providing adequate funding for the planning and implementation of LTC right-sizing initiative grants.
2. CMS' MFP funding restriction of providing assisted living through HCBS waivers on institutional grounds.
3. Criteria for being awarded a grant could be too limiting to be creative.
4. Not having the available community/HCBS workforce to align with a LTC right-sizing initiative.
5. Availability of appropriate data to fairly evaluate where rightsizing should occur.
6. Availability of appropriate data to fairly evaluate providers applying for a right-sizing grant.

5

Conclusions

The recommended strategies identified within this plan for each of the key system elements represent important steps toward building a strong system of LTSS. Collectively, they provide direction to the State when developing a redesigned service system that will afford individuals, even those with significant support needs, maximum choice and control over the type and location of their services. The planning retreat participants identified these strategies to represent the very important efforts necessary to reconfigure the infrastructure as well as needed improvements to services and processes used within that frame.

Through this stakeholder process, some common themes emerged across the strategies and system elements:

Partnership and collaboration – across all stakeholders – are key to all of the strategies. Leveraging existing relationships and forging new partnerships will be essential to make the system changes that will form the backbone of a right-sized system.

Simplifying, streamlining, educating and using resources strategically also emerge as themes across the issue areas. This emphasis is represented at the macro or systems level with strategies identified to utilize budgeting techniques and resource decisions that will incentivize the needed system movement. The strategies also emphasize individual-level considerations, as strategies encourage the State to make service and individual resource allocation decisions based upon objective assessments of individual needs and not solely based on diagnosis. The encouragement toward streamlining is to make the system efficient, cost effective and understandable to the individuals who use it and their families.

Supporting informal and formal care providers to ensure a quality workforce also emerges across many strategies. The compensation, supports and learning opportunities for this increasingly critical network is key to any strong HCBS system.

Additionally, there were commonalities in the identified challenges which Connecticut must overcome. Some of these challenges are posed by federal program requirements in Medicaid for HCBS and MFP, particularly as they relate to assisted living and the interface between Medicare and Medicaid. Others are State requirements such as rules around nursing delegation, direct admission to NF

requirements and safe discharge standards, differences across various agency requirements (around LOCs and financial eligibility) and service fragmentation that must be smoothed in order for seamless transitions and access to services to occur. A stark challenge also identified in each area is the lack of affordable, accessible community-based housing and transportation. Additionally, the adequacy and training of the needed network of support workers is a concern across the issue areas. Finally, fiscal considerations will be important as the State determines the extent and timing of expanded HCBS opportunities, any changes to provider reimbursement or the implementation of other strategies that may require resources. These challenges and others are not insurmountable but will require thoughtful deliberation and creativity to overcome.

As the recommended strategies identified within this report reveal, significant work on the part of the State to prioritize resources and develop timelines is required in order to address the critical needs identified and to realize the State's LTC rebalancing goals. Through application and consideration of the projected LTC needs at the State and local level and informed by a data book, the State can make pragmatic choices in determining where to allocate resources. Current and future LTC service users should be invigorated by the dedication and long-term vision of the State.

The next phase of development of the strategic plan will consider how the data, maps, and adopted strategies will affect supply and demand in the coming years. As the initiative unfolds, this information in conjunction with the experience of providers and local communities will be reviewed and analyzed to understand the interactions between the implemented programs, changes to the market (population, workforce, regulation, etc.) and provider experience. This view of the State's LTSS will continue to evolve as the variables change, but, with regular evaluation, they should provide an appropriate context for determining next steps in the process. Through the continued level of engagement and commitment of the State and the stakeholders, the goals of the initiative are achievable.

APPENDIX A

Statutory Authority

The authority to create this report can be found under Section 83 of Connecticut's Public Act Number 11-242 (AN ACT CONCERNING VARIOUS REVISIONS TO PUBLIC HEALTH RELATED STATUTES) establishing the requirements for a strategic plan, consistent with the long-term care plan established pursuant to section 17b-337.and which revises Section 17b-369 of the Connecticut general statutes. In summary, this bill outlines the following authorities related to the generation of this report:

- The bill requires the DSS commissioner to develop a strategic plan, consistent with the state's long-term care plan, to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions. He must include providers from all three setting types in the development of the plan.
- The bill permits the DSS commissioner to contract with nursing homes and home- and community-based providers to carry out the plan. It also permits him to revise a rate paid to a nursing home to carry out the plan. The bill authorizes the commissioner to fund plan initiatives with federal grants available under the Money Follows the Person Demonstration Program and the State Balancing Incentive Payment Program provisions in federal law.

The full text of this statute may be found at http://www.cga.ct.gov/2011/act/pa/2011PA-00242-R00HB-06618-PA.htm

APPENDIX B

List of Attendees

Agency	Invitee Name
AARP Connecticut	Brenda Kelley
Agency On Aging Of South Central Connecticut	Cynthia Scott
Agency On Aging Of South Central Connecticut	Julie Gelgauda
Apple Health Care	Brian Bedard
ARC	Quincy Abbot
Avon and West Hartford Health and Rehabilitation	Russell Schwartz
Bureau of Rehabilitation Services	Amy L. Porter
Bureau of Rehabilitation Services	Patti J. Clay
Central Connecticut Senior Health Services	Patricia Walden
Communities	George Ducharme
Companions and Homemakers	Linda Grigerek
Companions and Homemakers	Martin Acevedo
Connecticut Association for Homecare and Hospice	Tracy Wodatch
Connecticut Association of Health Care Facilities	Matthew V. Barrett
Connecticut Commission on Aging	Deborah Migneault
Connecticut Community Care	Sherry Ostrout
Connecticut Community Care - Northwest	Beth Mielcarek
Connecticut Community Care - Northwest	Judy DiTommaso
Connecticut Community Colleges	Jane Williams

Agency	Invitee Name
Connecticut Hospital Association	James Iacobellis
Connecticut Housing Finance Authority	Nancy O'Brien
Connecticut Legal Rights Project, Inc.	Karyl Lee Hall
Connecticut State Senator	Edith Prague
Connecticut Women's Education and Legal Fund	Alice Pritchard
Consultant	Phyllis A. Belmonte
Consumer	Jessica Dybdahl for Heather Northrop
Corporation for Supportive Housing	Sarah Gallagher
Department of Developmental Services	Siobhan C Morgan
Department of Developmental Services - Commissioner	Macy, Terry
Department of Economic and Community Development	Frances Messina
Department of Mental Health & Addiction Services	Barbara Bugella
Department of Mental Health & Addiction Services	Jennifer Glick
Department of Mental Health & Addiction Services	Laurel Reagan
Department of Mental Health & Addiction Services	Megan Goodfield
Department of Mental Health & Addiction Services	Pat Rehmer
Department of Mental Health & Addiction Services	Steve Dilella
Department of Public Health	Maureen Klett
Department of Public Health	Wendy Furniss
Department of Public Health - Commissioner	Jewel Mullen
Department of Social Services	Christopher A. Lavigne
Department of Social Services	Frances A. Freer
Department of Social Services	Mairead Phillips
Department of Social Services	Mark C. Schaefer

Agency	Invitee Name
Department of Social Services - Alternate Care Unit	Kathy A. Bruni
Department of Social Services - Bureau of Aging, Comm. & Social Work	Pamela A. Giannini
Department of Social Services - Commissioner	Roderick L. Bremby
Department of Social Services - Deputy Commissioner	Claudette J. Beaulieu
Department of Social Services - Financial Management & Analysis	Helen Chan
Department of Social Services - Financial Management & Analysis	Krupali Patel
Department of Social Services - Financial Management & Analysis	Lee Voghel
Department of Social Services - Financial Management & Analysis	Mari Spallone
Department of Social Services - Financial Management & Analysis	Michael J. Gilbert
Department of Social Services - Financial Management & Analysis	Nick Venditto
Department of Social Services - Money Follows the Person	Barbara Swenson
Department of Social Services - Money Follows the Person	Dawn Lambert
Department of Social Services - Money Follows the Person	Eileen Murray
Department of Social Services - Money Follows the Person	Karen M. Law
Department of Social Services - Money Follows the Person	Michael Rooney
Department of Social Services - Money Follows the Person	Paul Ford
Department of Social Services - Money Follows the Person	Tamara Lopez
Department of Social Services - Money Follows the Person	Vanessa Soares Bowden
Department of Social Services - Public and Government Relations	Carolyn Treiss
Department of Social Services - Public and Government Relations	David S. Dearborn
Department of Social Services - Rate Setting	Kathleen A. Shaughnessy
Department of Social Services - Social Work Services	Dorian J. Long
Geer Nursing and Rehabilitation Center	John Horstman
Geer Nursing and Rehabilitation Center	John Horstman

Agency	Invitee Name
Genesis Healthcare (attended for Dick Blinn)	Patricia Quinn
Interim Health Care	Andrea Matthews
Interim HealthCare	Ben Petersen
Law Offices of Sharon L. Pope, LLC	Sharon L. Pope
LeadingAge Connecticut	Mag Morelli
Long Term Care Ombudsman Program	Nancy B. Shaffer
Manchester and Vernon Manor Health Care Centers	Paul Liistro
Masonicare	Steve McPherson
National Alliance on Mental Illness of **CT**	Alicia Woodsby
National Alliance on Mental Illness of CT	Sheila Amdur
National Healthcare Association	Marvin Ostreicher
National MS Society	Susan Raimondo
New England Home Care	Kim Nystrom
New England Home Care	Nancy Leonard
New Samaritan	Bill Fairbairn
Nursing Home Administration	Rosemarie Clark
Office of Policy and Management	Anne Foley
Office of Policy and Management	Barbara Wolf
Office of Policy and Management	Judith Dowd
Office of Policy and Management	Susan M. Eccleston
Office of Policy and Management - Secretary	Ben Barnes
Office of the Attorney General	Henry A. Salton
Organization & Skill Development	Laurie Ann Wagner
Revera Health Living	Tina Thomas

Agency	Invitee Name
Saint Joseph Living Center	Lynn Iverson
Southwestern Connecticut Agency on Aging	Chris Crain
Special Assistant	Khampasong Kantivong
State Commission on Aging	Julia Evans Starr
State Representative	Jonathan Steinberg
The Connecticut Association of Personal Assistance, Inc.	Cathy Ludlum
University of Connecticut Health Center - Center on Aging	Julie Robison
University of Connecticut Health Center - Center on Aging	Martha Porter
US Department of Housing and Urban Development	Suzanne Piacentini
VNA Healthcare, Ind. Living Svs	Michelle Parlato

* Mercer staff was in attendance to facilitate all stakeholder meetings

APPENDIX C

Formal Comments

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

January 4, 2012

Connecticut Department of Social Services
Money Follows the Person Program
25 Sigourney Street
Hartford, CT 06106
Attn: Dawn Lambert, Program Director

Dear Dawn:

Thank you for this opportunity to submit additional comments on the draft Long-Term Care Right-Sizing Strategic Plan (from the input compiled and recorded at the November 30, 2011 strategic planning retreat). Please consider these additional comments as a supplement to the comments submitted on December 2, 2011, which continue to reflect the views of the Connecticut Association of Health Care Facilities (CAHCF) concerning the draft plan.

As is customary in governmental reports of this type, we are asking that our submitted comments be included as an addendum to the final report.

CAHCF looks forward to our ongoing participation in this stakeholder input process as Connecticut seeks to rebalance and right-size its long term care system in a manner which continues to recognize the strong need for high quality and financially viable nursing homes now and in the future.

Sincerely,

Matthew V. Barrett
Executive Vice President

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Connecticut Association of Health Care Facilities (CAHCF) Comments on Long-term Care Right-sizing Strategic Plan (draft) – January 4, 2012 – page 1

Page 3 – the draft report states: "A 2011 analysis of adults age 31 and over using Medicaid LTC services shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and in 2008: Total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and 0lder."

CAHCF Comment: The final rightsizing report should acknowledge that the unusually large numbers of persons age 90 and over in Connecticut from the most recent data, in large measure, explains higher nursing home utilization rates and thus should be a factor in the future NF/HCBS projections.

> The November 2011 report *90+ in the United States: 2006–2008* published by the U.S. Department of Health and Human Services and U.S. Department of Commerce offers an explanation as to why Connecticut needs more NF beds than the norm --- Connecticut ranks second in the number of persons over 90 year of age. The report states, "An older person's likelihood of living in a nursing home increases sharply with age." The report further states: "Almost everyone (98.2 percent) residing in institutional group quarters (e.g., nursing homes) had some type of disability, compared with 80.8 percent of those who lived in households or non-institutional group quarters. For most measures of disability, rates for those institutionalized were drastically higher than for those not institutionalized. The largest differences were in cognitive ability (concentrating, remembering, or making decisions) and limitations in dressing or bathing (indicator for ADL), with the institutionalized population aged 90 and older more than twice as likely to have those limitations than their non-institutionalized counterparts." Accordingly, age is the driver with respect to institutionalization and in that CT ranks second in terms of its over 90 population in the over 65 age cohort, demonstrates why more nursing home beds per 1,000 population are needed in CT than the norm. There is a simply correlation that explains the situation in CT --- CT ranks second in the nursing home rate per 1,000 population because CT ranks second in the percentage aged 90 and over of the age 65 and over.

Additional CAHCF Comments:

Page 12 - Add: Strategy: Create mechanisms to ensure quality in the care provided through HCBS. Add Tactics and Metrics for this Strategy. Training alone is not sufficient.

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Page 22: #1.a. Change "LTC mantra" to "HCBS mantra."

#1.b. The authors of the draft report assume that NFs can somehow operate without physician orders, which is quite simply not possible. The issue is not having to have physician orders. The problem is how to obtain them outside the hospital setting.

Page 27 - Many of the recommendations here will require federal as well as state law changes. For example, if a "person-centered assessment" is developed, will NFs then be required to do that assessment in addition to the current 56-page MDS already required?

#15. Delete. Hospice services are already widely available in NFs.

#16. Clarify by adding "CHANGE THE FEDERAL exclusion of LTC providers for grants for electronic medical records."

January 4, 2012

Dawn Lambert
Project Director
Money Follows the Person Rebalancing Demonstration
Department of Social Services
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Re: Comments of LeadingAge Connecticut on the Draft Right-sizing Report

Dear Dawn:

On behalf of LeadingAge Connecticut, I would like to thank you for this opportunity to submit comments on the draft report of the right-sizing strategic planning retreat that was released on December 16, 2011. We appreciated the opportunity to participate in the retreat and the webinars that followed. We understand that our comments today are to be limited to edits and corrections related to the actual strategic planning retreat. We have also taken into consideration the written comments that we submitted immediately following the retreat. I have attached our page by page comments regarding the draft report on the forms provided by your office.

I would also like to offer the following general comments. We submit these general comments knowing that the report will be read and referred to by persons outside of the planning process and with limited knowledge of the long term care field. It is important that the final report not be misinterpreted or misrepresented by such readers.

- We have included in our submitted comments a suggestion that the report's title be changed to represent that it is not in itself a strategic plan, but rather a report of the potential strategies that were raised during a planning retreat. We would further request that the report include a disclaimer or explanation stating that while the strategies included in the report were all raised as a part of that planning retreat,

the report does not represent a consensus agreement or an endorsement of the strategies by the participants.

- The phase one projections that are set forth on page one are estimates of the future demand, but no explanation is provided to the reader as to how that will be measured, monitored or adjusted over time, even though we have been told that they will be reviewed every six months. While the potential phase two data analysis could include a live data book, it would be helpful to make it clear to the reader at the onset of the report that the macro view projections will be closely monitored. We would also like to note that we would find a detailed a trend analysis over the projected time period to be very helpful and we are looking forward to the second phase of the data analysis.

- We continue to question whether “65 and over” is this the correct demographic to use in estimating demand for long term care services and supports. While our membership reports a higher average age of entrance into the system for aging services, there are individuals of all ages who will potentially need long term care services and supports. Again, we look forward to the second phase of the data analysis to provide more detail into the demand trends for all ages and demographics.

- We are hopeful that the second phase of data analysis will include current and projected demand for nursing home beds for uses other than Medicaid funded long term care stays such as for short term rehabilitation stays.

- The report never explains the next steps in the planning process or how the actual strategic plan will be developed or implemented. This information is important to the reader’s understanding of the report.

- We note a general lack of recognition that the discontinuance, diversification, or development of long term care services and supports is a not only a strategic decision, but is also a business decision for providers and must be viewed and evaluated within that context. Issues such as financial and contractual obligations, economies of scale, market share, and capital investment are very important and must be taken into consideration when making these decisions.

- There is an emphasis in the report on the creation of new businesses/entities and little recognition of new services derived from potential partnerships and collaborations between existing providers/businesses. This is notable in the tactics and metrics

sections where there is a reliance on measuring the development of new businesses rather than measuring client outcomes, satisfaction and experience.

- There is also a lack of potential strategies and tactics to achieve nursing home modernization. The need to invest in nursing home infrastructure and modernization, including electronic medical records and technology, is crucial to the entire long term care system and therefore to the rightsizing planning process.

- We again would encourage the state to create a collaborative and efficient regulatory and reimbursement environment that is adaptive and receptive to individual provider's forward thinking ideas and planning. Such an environment would encourage providers of the long term care continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations.

Thank you again for the opportunity to provide these comments and we look forward to continuing our involvement as the planning process moves forward.

Sincerely,

Mag Morelli

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